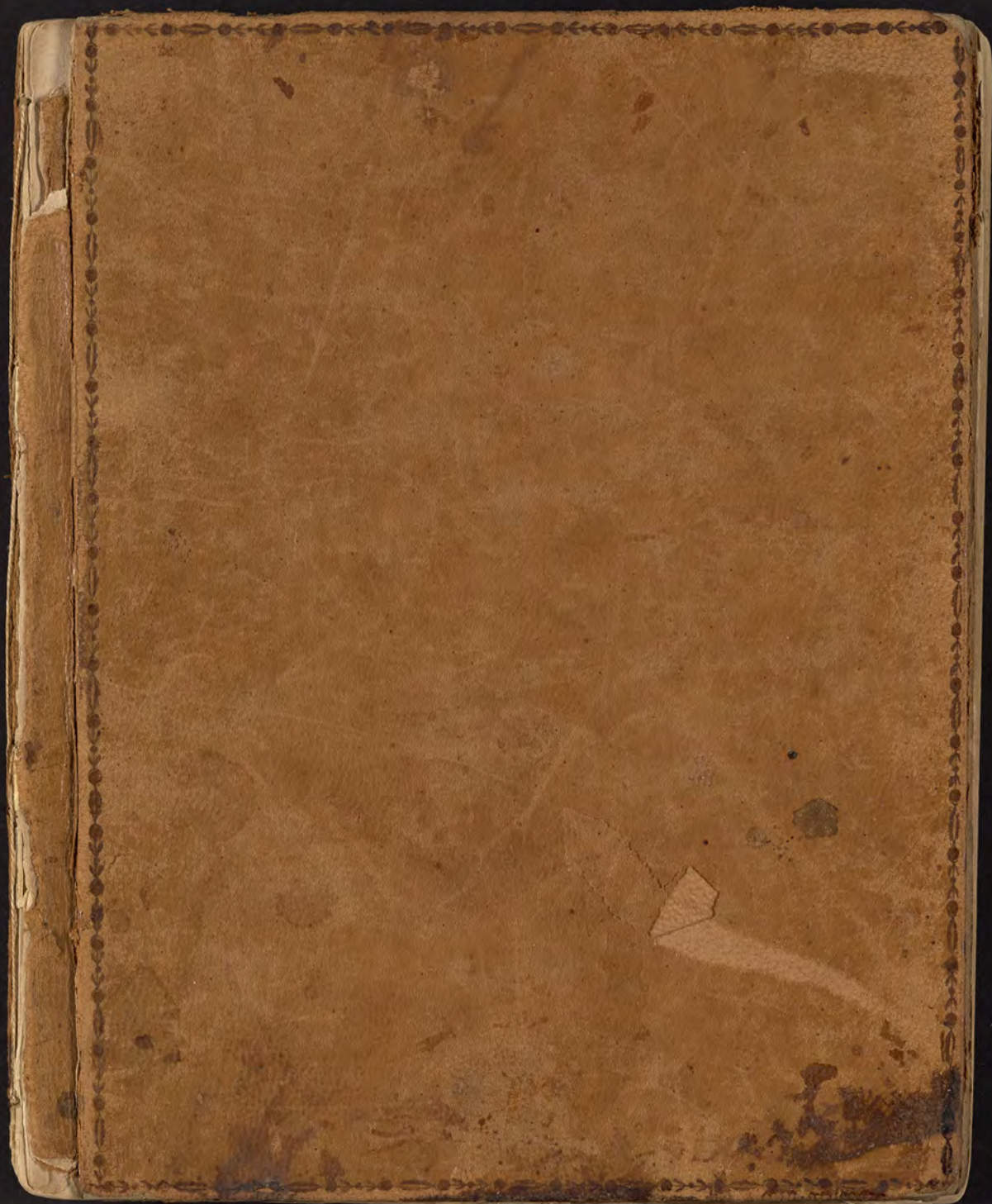


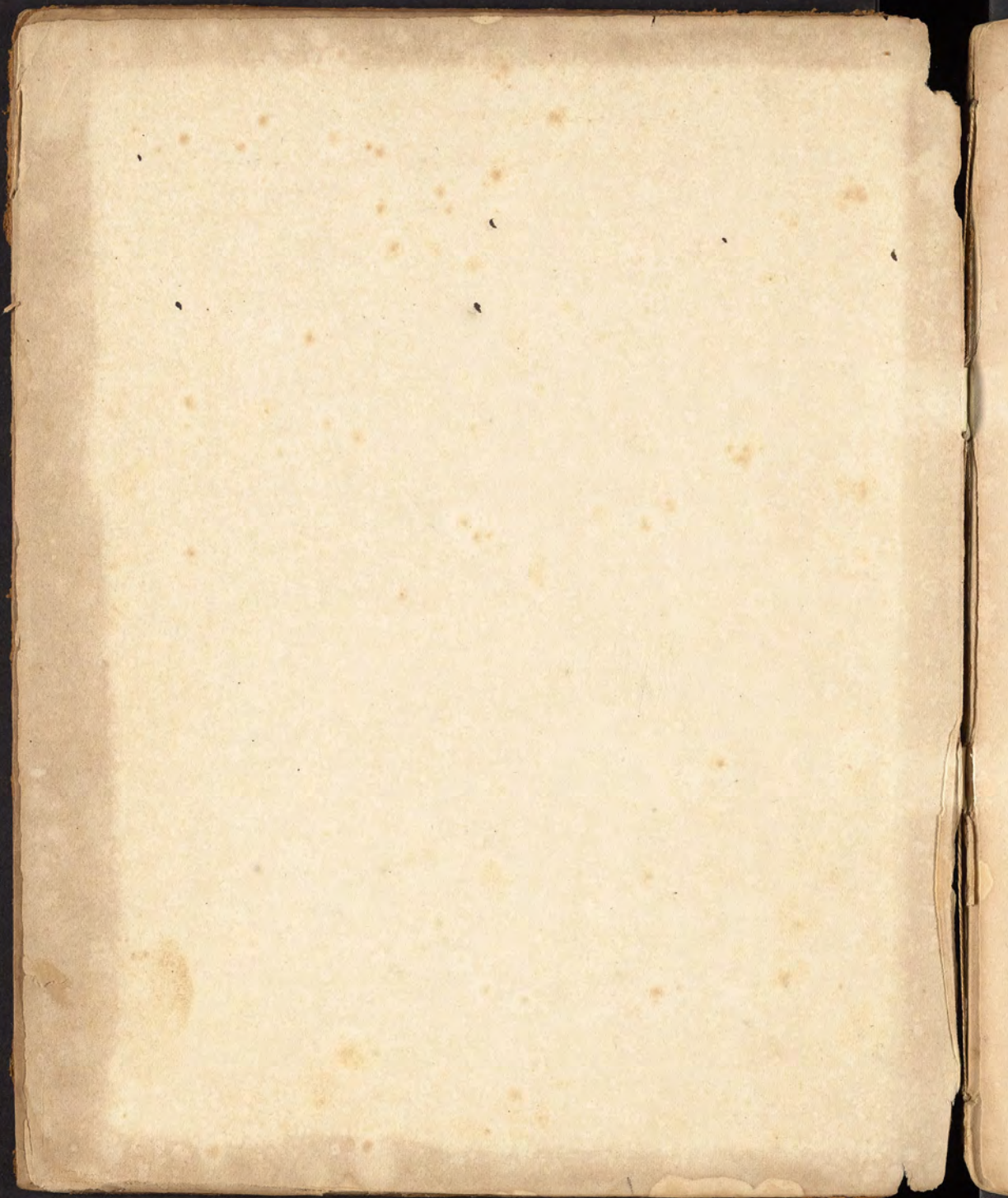


Samuel H. Stout

Nashville

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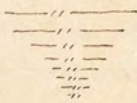


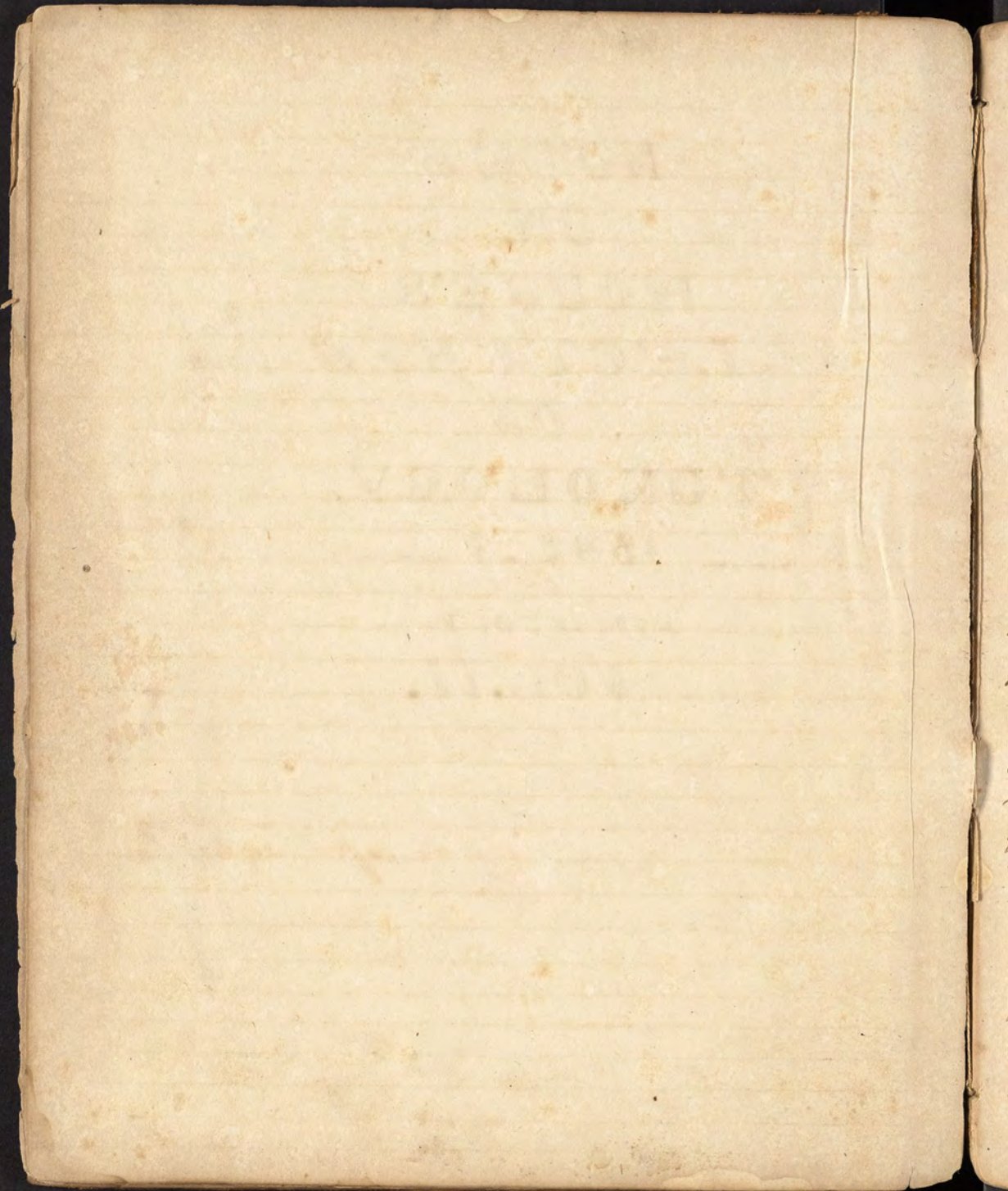
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NOTES
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— " — LECTURES — " —
ON
TOKOLOGY.

— " — 1842-3. — " —

— " — S. H. STOUT. — " —

— " — VOL. II. — " —

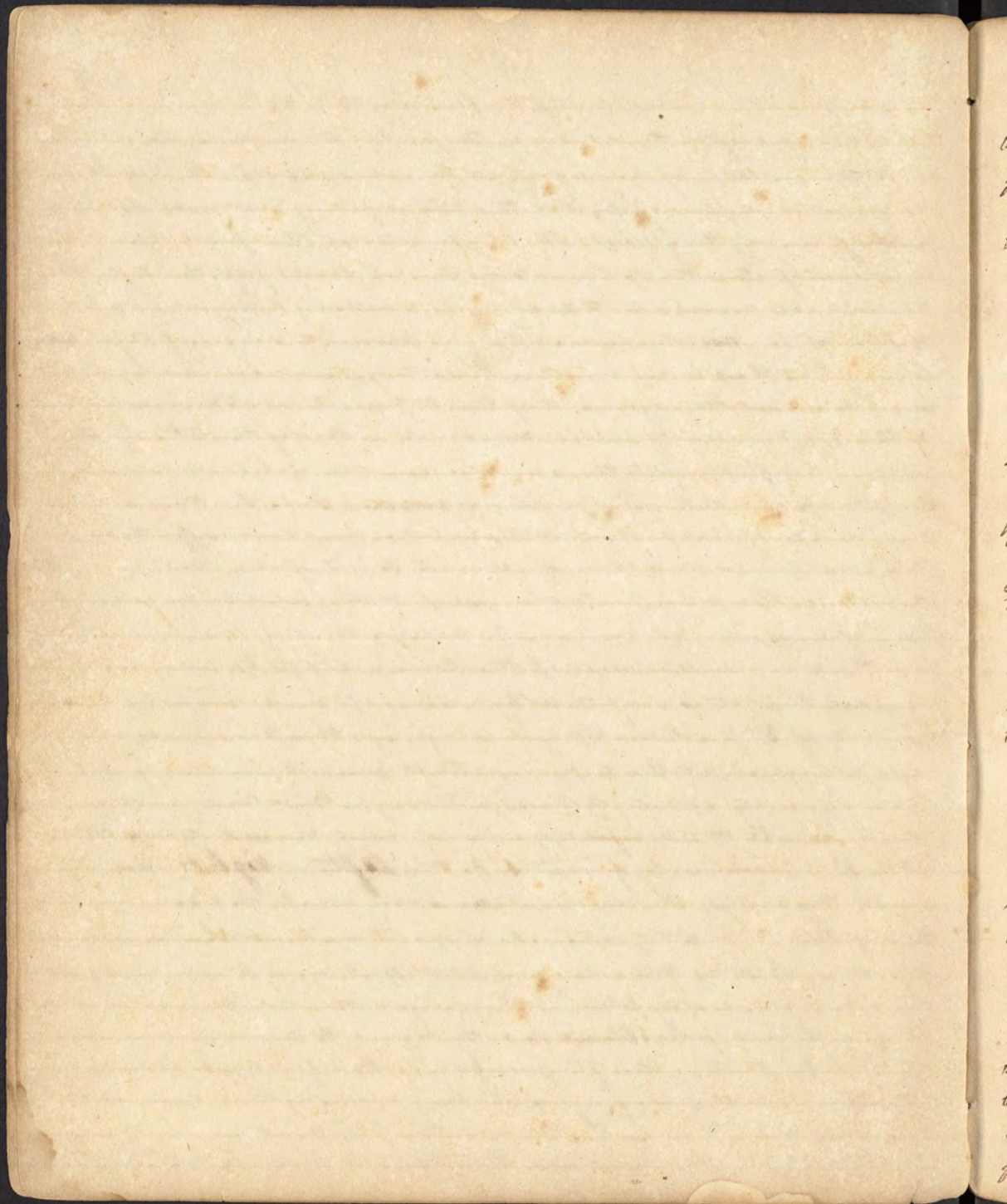




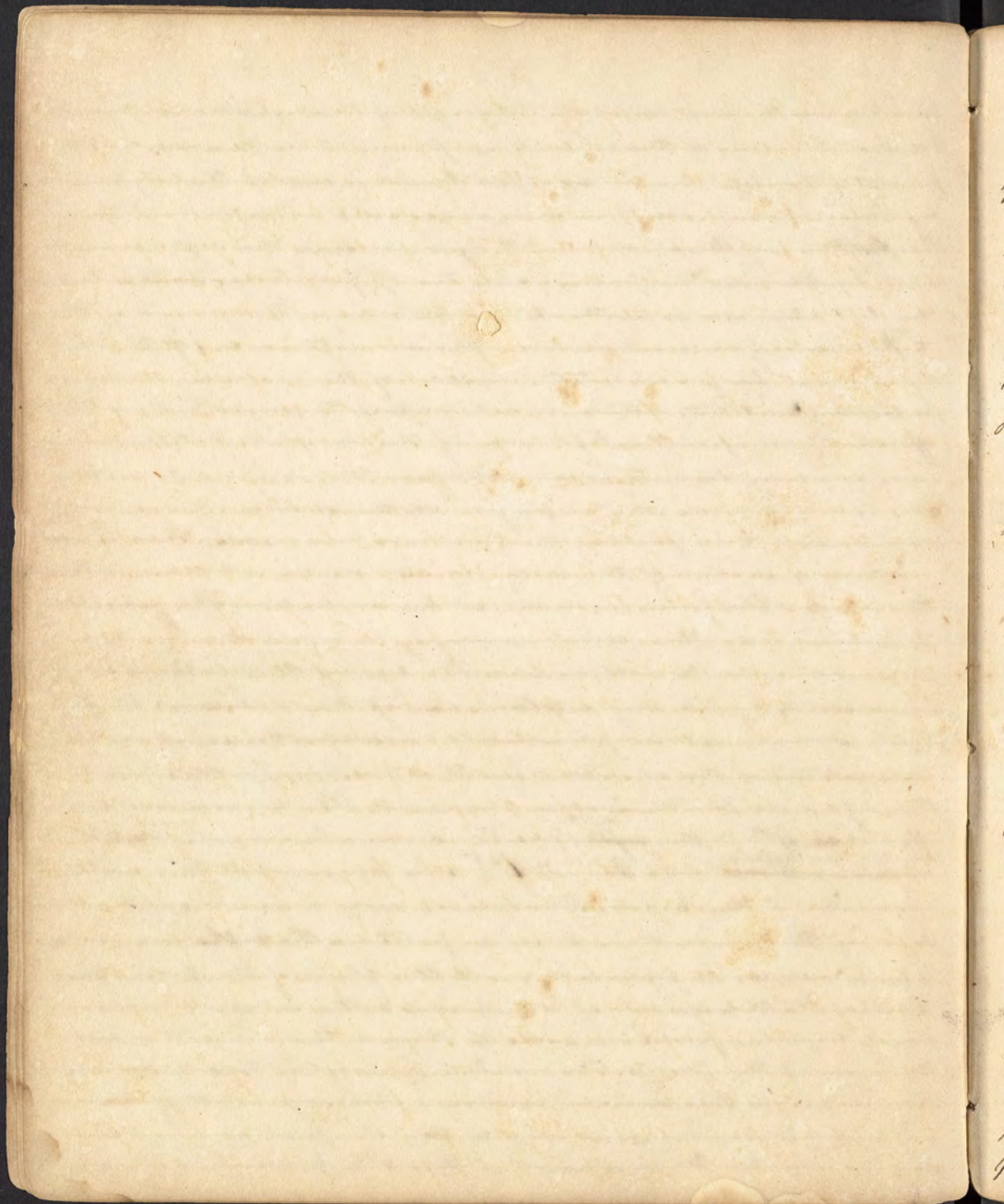
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Lecture XXX. January 20th '43

Be careful after the delivery of the child to examine the uterus as to the existence of hemorrhage. It may exist even though there be no external flow of it. For the uterus falling over into left lumbar region may be filled with blood without the practitioner being aware of its extent. The uterus can be easily felt through the abdominal muscles, & its condition, whether flabby or in a contracted state, ascertained. If it feel hard we may feel safe, as much as this is an evidence that tonic contractions have taken place. — Management of the 2nd position. The mechanism in this position is very much the same as that of the 1st. If the rectum be full after the commencement of labour, during the process of rotation it will be evacuated. In this event the female should not relax her bearing down efforts, and the practitioner should not allow it to interfere with him in his operations. He may protect himself & the female by means of the napkins with which he is provided. But if he arrives before the commencement of the second stage he should always see that it is emptied by means of an enema. — Management of 3^d position. If you recognize this position when the head is engaged at the superior strait, since there may arise some difficulty about its passage through this strait, with your finger against the occiput you may easily convert it into the 1st or 2nd position, by pressure to the ~~left~~ or ~~right~~. Having effected this change the mechanism is very much the same as that of the 1st or 2nd position. In truth it is converted into one or the other. But if this change is not effected, it is our duty to facilitate flexion by placing the finger behind the occiput & forcing it backward, (that is with regard to the maternal pelvis,) or by putting the finger against the forehead during a pain provided your fingers be long enough. After the head after this being delivered as in the former positions, you may facilitate rotation of the shoulders. This should be done not by this



ting the head, but by placing the finger of the right hand against
 the left shoulder of the child and forcing it backwards; or the
 finger of the left hand against the shoulder of the right side
 & forcing backwards. You can always act with advantage on
 the scapula of the child. In the former case the right shoulder
 will be towards the pubis as in the 1st position, in the latter
 the left shoulder as in the 2nd position. — Management of the
 4th position. You must increase flexion in this case; if the oc-
 ciput must be forced into the hollow of the sacrum you must
 increase facilitate rotation by acting upon the right side of the
 forehead or upon the left side of the occiput. Rotation occur-
 ring you may advantageously act upon the occiput to increase
 flexion by introducing the finger into the rectum. You may al-
 so increase it by pushing the forehead backwards. There is dan-
 ger here of rupture of the recto-vaginal partition & delivery through
 the anus. The perineum must be supported. The question
 as to how long the perineum may be supported is a very
 difficult one to determine. The life of the child is here
 involved, by too long a retardation of the delivery. Rest-
 riction here must be permitted to occur spontaneously. Facili-
 tate rotation of the shoulders in this position. In this position
 the left will be the main shoulder. But in most cas-
 es ~~the 4th & the 5th positions may be converted into the~~
^{case of the 1st position} ~~superior~~ ^{into 2nd & 3rd} by bearing on the an-
 terior side of the head. It requires only a push sufficient
 to bring the occiput in such a position that it may, when
 a pain occurs, be forced against the floor of the pelvis just
 anterior to the spine of the pubis & the rotation will
 easily be accomplished so as to throw the occiput under
 the arch of the pubis. The mechanism after this will be
 the same as the second position. Management of the
 5th position. Convert it into the 1st, just as directions
 for the last. Management of the 6th position. This is



more rare than either of the others. The reason of it is that it is converted without any interference on the part of the practitioner into the 9th or 5th. If it is not converted you may do so (indeed should always do it) by acting on the side of the forehead or if the finger be long enough upon the occiput. Do not attempt to change it further ~~from~~ into the 1st or 2nd since there would be rotation of the head upon the body to a dangerous extent. — Management of the 3^d stage of labour. This is the most dangerous of all the stages to the mother. You should wait after the delivery of the child until there is a pain. If it do not occur in 10 or 15 minutes I ~~think~~ ^{think} that practitioners may interfere. As soon as the child is delivered I generally direct the patient to lay on her back because it relieves her very much after having laid so long on the side. It also prevents the tendency to hemorrhage by allowing the uterus to contract with more facility, and gives the practitioner the power of taking hold of the fundus & pressing it against the pubis to excite it to contract. If it do not contract you may rub with the hand on the fundus of the organ. To facilitate the delivery of the cord you may use traction efforts upon the cord, request the patient to bend down, pull it in the direction of the ^{axis of the} superior strait, by introducing the fingers of the right hand and making ~~them~~ a pulley whilst traction is made with the left. The excuse made by some when they are not able to deliver the placenta is that it has grown to the side of the uterus. The reason of it is because they do not pull in the proper direction. After the placenta enters the vagina make traction in the direction of its axis. Bad consequences sometimes arise from leaving the portions of the membranes in the ~~the~~ vagina or uterus; they produce irritation by their putrefaction. Frequently two-

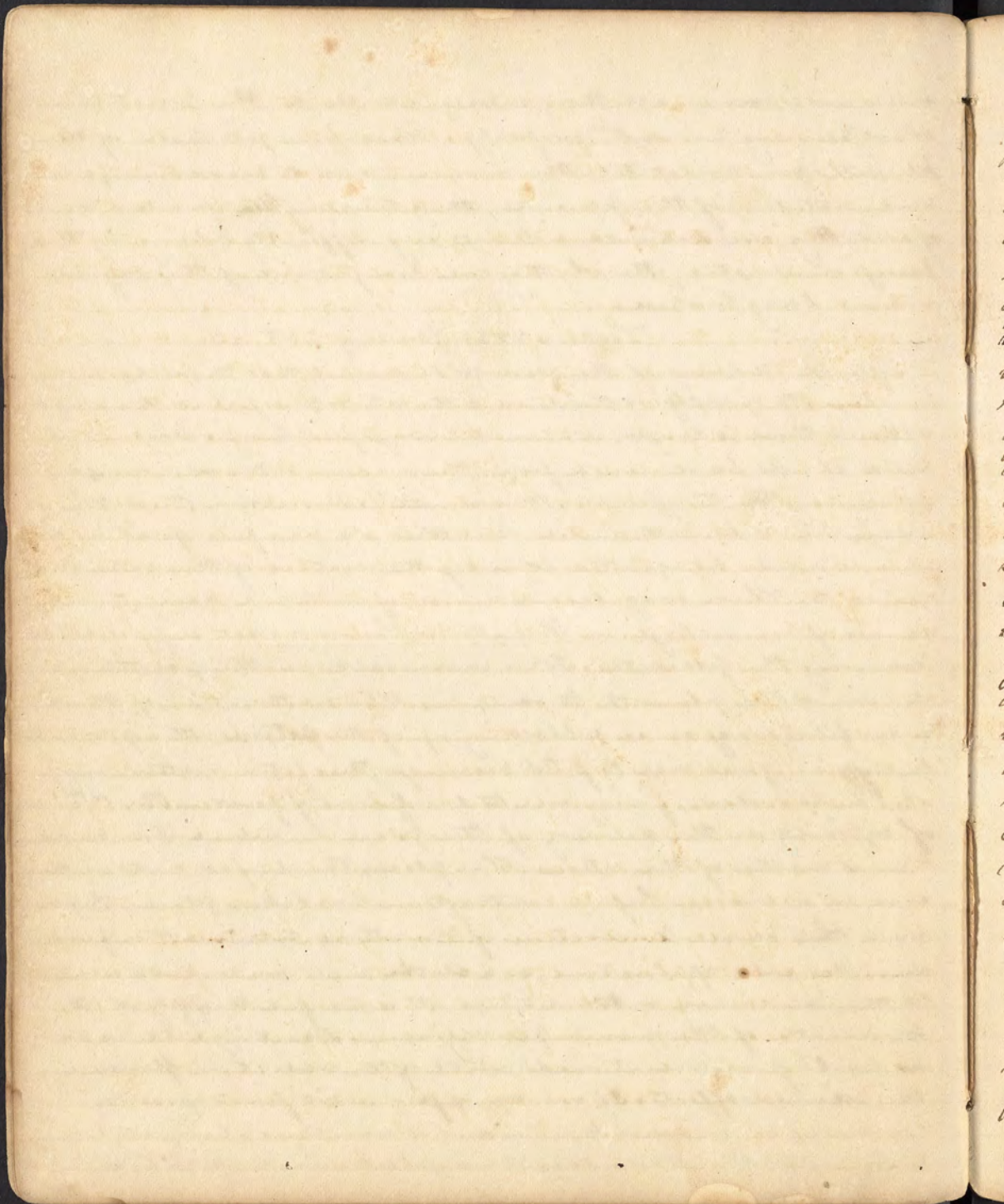
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men will ascribe all their subsequent ills to the practitioner - "not clearing her out" properly. When you get hold of the placenta you must tell the woman not to be down, and make rotation of the placenta, thus twisting ~~them~~ ^{it} up into a kind of cord. They are delivered without any difficulty & being by this process much strengthened they are brought out of the vagina without being broken.

Lecture XXXI January 23rd '43

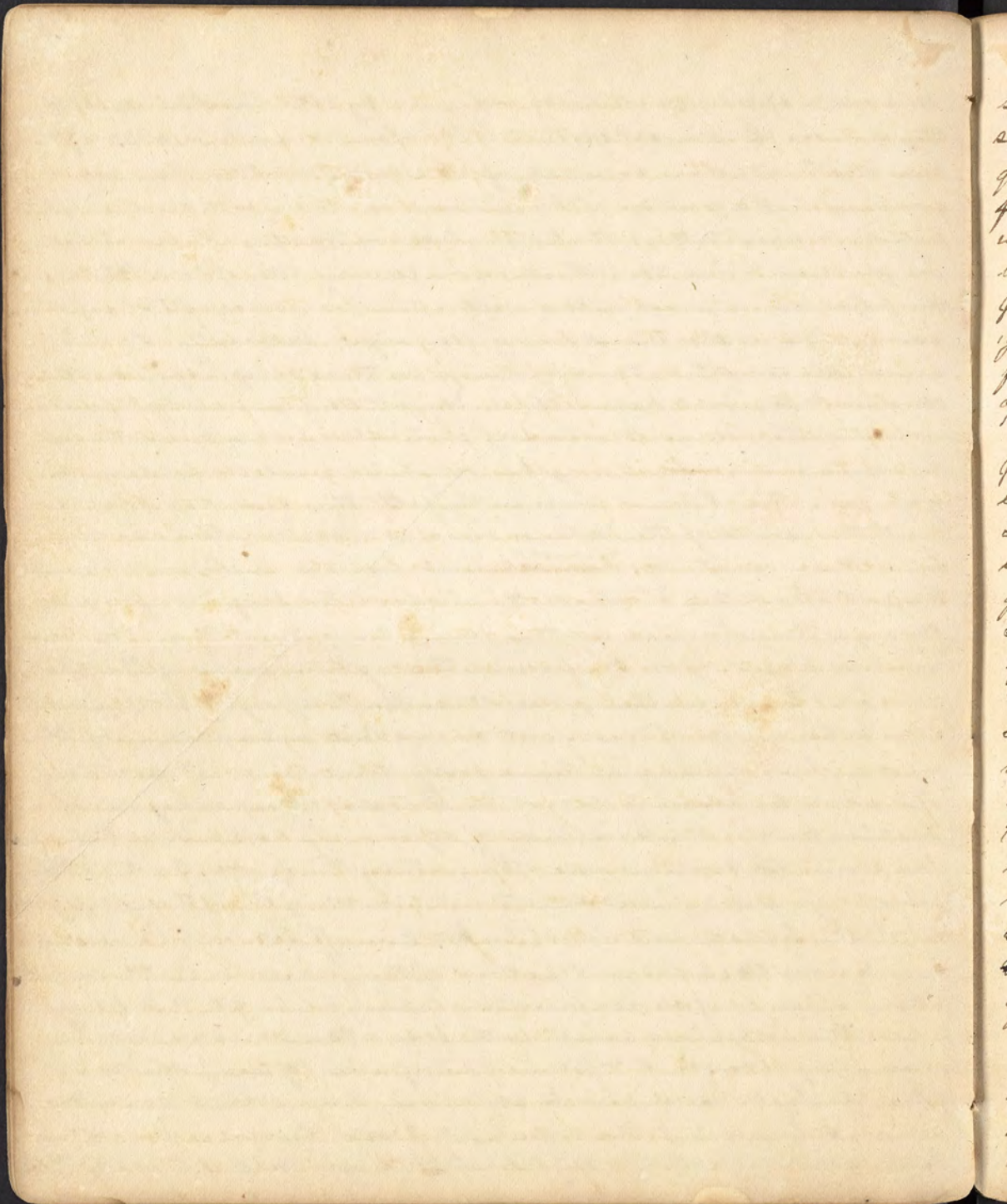
After the delivery of the placenta be careful that there be no hemorrhage. If by applying the hand to the uterus you feel it to be soft & flaccid there is danger; it should always feel hard. Coagula of blood should be removed from the vagina & the ~~uterus~~ ^{uterus} by introducing ~~the~~ two fingers. It is sometimes necessary that the whole hand be introduced. But this is a painful operation & should never be resorted to unless the nature of the case requires it. These coagula are sources of irritation, & sometimes causes of hemorrhage. — Sometimes there is great difficulty in delivering the placenta. It is inexcusable in the practitioner to permit the placenta to remain. — The contractions of the circular fibres may cause a blocking up of the uterus, the placenta putrifying, gives rise to fetid discharges, this fetid matter may also be absorbed, giving rise to low forms of fever. — The 1st cause of difficulty in the delivery of the placenta which I will mention is inertia of the uterus. The placenta should not in this case be delivered before contraction has taken place. To produce this cause locomotion of the uterus towards the fundus. Use cold applications, as a cloth wet with cold water, to the abdomen & sometimes it is useful to apply it to the mouth of the womb per vaginam. Drinking cold water as heretofore mentioned will often assist in producing the desired effect. If you can safely wait for its operation Ergot may be resorted to; indeed it is sometimes absolutely necessary after the other means have failed. For the West Indies



it is the custom amongst practitioners to resort to the introduction of a peeled lemon, to hasten the delivery of the placenta. It often happens that before the regular practitioner arrives that the ignorant midwife or other person in attendance has broken the cord in the efforts to pull out the placenta. In this case it will be necessary to take hold of the centre of the placenta. A 2nd cause of these difficulties is enlarged placenta. It is sometimes so large that in endeavouring the mouth of the womb it is arrested & blocks it up. In this case it is necessary to take hold of the placenta during ~~the~~ the pain & draw it outwards. - A 3^d cause is the state of the Uterus itself. Sometimes the os tincae is firmly contracted so as to prevent its delivery. We may in this case wait a while, as it may without assistance from art relax itself. It is dangerous to stimulate the uterus as it may give great pain since in stimulating the fundus & body you also increase the tension of the circular fibres. Besides this there is a liability in the violent contractions of the uterus to a rupture of its walls. You may resort to an enema, or warm application of the abdomen, or an opiate. The gentle means to dilate the os uteri by introducing one finger & then another & hook up with them the placenta. These females will bear venesection, since this state in many cases is ascribable to debility. I consider ergot a dangerous remedy since it produces an universal contraction of the organ & hence can do no good, but for the reasons above stated may be productive of much harm. When the uterus is universally contracted, one may resort to an enema, warm applications externally, venesection, or an opiate either by the mouth or rectum. The opiate alone will be found in most cases to produce the desired effect. We may resort if necessary to some instrument, the blunt hook, or forceps made after the fashion of Bond's gutlet forceps, or the forceps of any own invention, which are so constructed as to be introduced into the uterus shut so as not to occupy

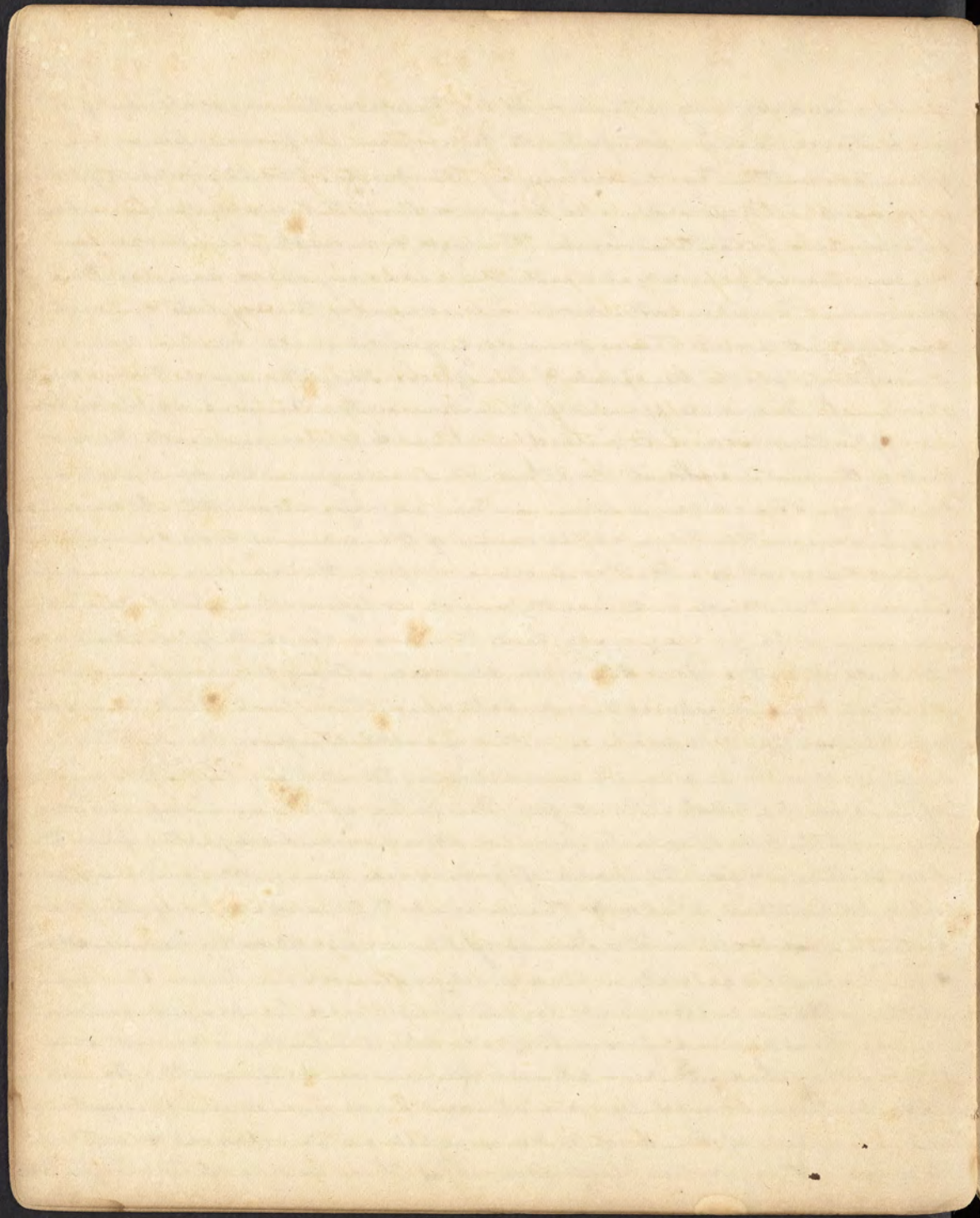
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as much space as usually occupied by other instruments of this kind. Dr Dewees' crochét is too slender and is a dangerous instrument on account of its sharp point. - There may sometimes be contraction of the internal os uteri, or a contraction higher up constituting the hour glass contraction. These states are produced by inertia. The hemorrhage may take place below the fibres which produce this contraction, or it may take place above without the blood being discharged externally. To determine this condition, the crochét may be traced up as far as the stricture, & the part below will be felt as if somewhat funnel shaped. The contraction of particular fibres & inertia of the remaining ones, may be exhibited under an infinity of shapes. This I have frequently felt the circular fibres about the mouth of the uterus in a contracted state. To overcome these resistances ~~cannot~~^{reverse} must be had to stimulation of the part above the stricture; & introduce the finger or fingers through the stricture at the same time that the other hand is placed upon the fundus through muscles of the abdomen. Embrace the placenta with the fingers stretched out. The patient will often cry out during this introduction of the hand, but after you have fully determined that the operation is necessary do not be deterred. Suspend your operations during the existence of a pain. If adhesions between the placenta & uterus exist, by putting the pulpy part of the finger or fingers against the uterus you may tear them up gently. If the adhesions cannot be broken off, it will be necessary to leave the adherent portions of the placenta in the uterus. There is danger of diseased action taking place at these places where the adhesions exist, both from the disease which originally produced it & from putrefaction of the portions of placenta left. Use opium to irritation, keep down vascular action, & wash out the womb at least twice a day. This latter operation should not be left to ignorant nurses, but



should be carefully attended to by the practitioner himself or some other person competent to perform it from being acquainted with the anatomy of the parts. For the proper performance of it you should have a long tube which may be introduced into the mouth, through which the water may be injected. A gum elastic catheter will very well answer this purpose. Sometimes the cord is broken by the efforts of some ignorant person & then your only guide will be in your familiarity with the feel of the placenta, therefore take every opportunity to make yourself familiar with the feel of placenta.

— After the child is delivered it should be placed parallel to the soft parts of the mother until it breathes. This will generally be denoted by a cry. The child is born in an asphyxiated state. It should cry lustily, & the blue appearance of the skin should disappear before the cord is cut. For if done before the child may be engorged with blood & its health more or less impaired. I do not consider it to be necessary that the cord cease to pulsate before it is cut. You should choose a strong round ligature & try it in two places & cut between. The fact that the circulation in the placenta is not dependent upon the mother would seem to make it unnecessary that the placental end of the cord be tied. But for the sake of cleanliness, as retaining the blood which would otherwise be spilt upon the bare clothes, & for the sake of prudence, since there may possibly be another child in the womb & the vessels of its placenta inoculate with those of the one already delivered; ^{therefore} the hemorrhage from this cord would involve the life of the other child. One ligature should be placed 1 inch or an inch & a half from the child, & another about an inch from that; & an cut should be made between the two. The ligature should be very strong since you have the gelatinous portion of the cord to tie as well as the vessels, & rather to make the proper impression ^{on} the vessels of through this



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gelatinous mass. The ligature should be drawn very tight. It is a disgrace to a practitioner to find that hemorrhage is taking place from the cord owing to the want of the proper tightness of the ligature. - The scissors should be sharp; be careful not to place them on the head, & make the nurse lay them down before you put the child in her hands. For you must remember that however great may be the moral excitement which surrounds you (and it is often very great) it is your duty to be calm & collected. To be so under these circumstances is difficult for the young practitioner. Therefore be on your guard, & attend to these little matters. Wrap the child up in flannel & place it in some warm place, taking care in all instances that its nose & mouth be unincumbered; it had better not be placed in the same bed with the mother. It should be laid on its side, so as to keep back from the accumulation of mucus it is liable to have its respiratory passages clogged. It may be thus left until the mother receives the proper amount of attention. The mother & child will require some further attentions of which we will speak at the next lecture.

Lecture XXXII. January 25th 1843.

I should have remarked at the last lecture that you must carefully examine the cord before tying it, for fear of embracing a congenital umbilical hernia in the ligature. Be careful in lifting the child to support its head. I always think it best to take it up by the chest with the thumb in one axilla, & the forefinger in the other, allowing the head to fall downwards, being flexed. No injury can result from this position. After this wrap the child up and lay it aside in some convenient & comfortable position, not in bed with the mother. - The child may not be in a physiological position. It may be still born; in some of these instances it is really dead, but in many the vital actions are either so much depressed as to be scarcely perceptible or they are un-

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suspended. You should always examine carefully, & never give up
 until you have resorted to the proper means of reanimation. There
 are two associations, ^{to} which I will call your attention, viz Asthenia &
 Asphyxia, 1st Asthenia, this is a condition which is dependent on re-
 al weakness, or on a deficiency of the vital actions. It is found
 in children which are born prematurely, or have not assumed at
 that degree of development which will enable them with ease
 to maintain a separate & independent existence. It is apt to be
 met with in those born at the 7th & 8th months & ^{sometimes} ~~often~~ in
 those born at the full period. These children are very emacia-
 ted, their skin is in folds & of a livid colour, the features & extremities
 are contracted giving them the appearance of old persons & are
 hence said to resemble their grand parents. They seldom breathe
 well, & sometimes ~~do~~ to grow without taking full & easy inspira-
 tions, do not stop a child's legs about which is born in this con-
 dition, do nothing which will fatigue it; apply dry heat by means
 of towels, sometimes you may resort to stimulating applications
 to the surface, as spirituous liquors; sometimes you may use
 a brandy & water injection, put it in a basket or something
 which will allow of moving the child without fatiguing
 it. It is better to feed it without ~~for~~ leaving it to the mother's
 breast, feed it with gum water or what is best sugar & water
 on a little soap which it will be able to suck. 2^d Asphyxia.
 This is of two kinds, viz simple & congestive, the former being
 a commencement of the last, In an asphyxiated state the
 child looks as if dead, sometimes an indistinct pulsation
 in the cord is felt. It is a state in which the vital actions
 are suspended. There is a suspension of the respiratory &
 the circulatory functions. The causes may be arranged un-
 der two heads, 1st those which take place during the pro-
 cess of parturition. As pressure upon the child's head, pres-
 sure upon the cord, & a squeezing of the placenta between
 the ~~and~~ child's head & the uterus. Sometimes the cord

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is drawn around the neck of the child in such a manner
as to ~~be~~ cause a stoppage of its circulation. The 2nd set of
causes, are those which arise after its birth. The respira-
tion may be impeded by the cord being tightly drawn
around the neck so as to impede the establishment of
respiration. The cord must be loosened, carefully avoiding to
pull the end towards the umbilicus. Sometimes the mem-
branes cover the face & head. This is called a caput. These of
course must be removed. The nose & mouth may be stopped
up by the immersion of the face in the fluids which
are about the mother's parts, or even by the bed clothes.
The simple asphyxia or state of syncope is characterized by a
pallor of the skin, & want of respiration. In the apoplectic
state or congestive asphyxia there is little or no respiration,
the vessels are loaded with blood, & little or no pulsation can be
felt. Authors speculate a great deal about it, but my own opin-
ion is that they proceed from the same cause, & only differ in de-
gree. The first object of attention should be to remove all me-
chanical obstructions; the best plan is to pass the fingers in
to the ~~of~~ mouth when it is wished to remove mucus from
about the glottis. Never place the child on its back. At-
tend to the pulsations in the cord; do not separate it
until the pulsations cease beyond all doubt. Use not ~~the~~
bathing, & afterwards dry the child well. To prevent the cold
which may arise from evaporation. By this means you
stimulate the skin & through its capillaries the general
circulation. Dr. Cullen was partial to the use of dry heat. After
the bath you may use friction with warm clothes. You may
also resort to dry rubbing with the hand or warm cloth, or an
stimulating injection. Stimulate the muscles by ~~drugging~~
Have you do not soant the antinurse effect of the cold.
Therefore as soon as the ^{cold} fluid is thrown on wipe it off
Procure respiration by judicious pressure upon the

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chest. If the child can be made to breathe once, it may generally be saved. Some think, by pulling the sword down-wards we may assist in attempts to institute respiration by expanding the ~~deep~~ chest in a perpendicular direction. But I think this a dangerous practice. Electricity, electro-galvanism & electro-puncture to very little good & are now seldom resorted to. The introduction of air into the lungs I do not find effectual because it is not an easy feat to perform, & when it is the air introduced is not of a proper quality. By pressing the larynx backwards you close the oesophagus, & open the glottis. This being effected you may either ~~insert~~ operate with the mouth inserted or introduce a bent tube into the glottis. Rubbing the child roughly is in my opinion often very effectual. In the convulsive asphyxia bleeding may sometimes be necessary. I have recurrent throwing a loose ligature around the sword & then cutting it off. But I think it a better plan to throw a loose ligature around the sword & cut the umbilical vein only, since the circulation through the arteries may then be unimpeded & the dangers which would arise from a too early separation of the child obviated. - There are sometimes certain local affections which will require of our attention. The presenting part of the child's head from being ~~pressed~~ pressed upon by the os uteri is often very much enlarged from the accumulation of blood or serum. This is called technically the caput succedaneum. The margin of this tumour almost always presents a hard & depressed edge which should not be mistaken for a fracture. Fracture of the head is exceedingly rare. Nature cures such complaints. Therefore let it alone. Sometimes from interference the natural process is interfered with & inflammation or even mortification ensues. The best applications are cold & astringent ~~for~~ ~~ta-~~ ~~tion~~ lotions, as lead water. Leeches are of doubtful

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propriety from the danger of erysipelas. Some recommend ^{it}
 opening the tumour freely, others use caustics. This I think bad
 practice. If puncturing is to be resorted to the couching needle
 is an instrument sufficiently large for this purpose. — When
 the child has been thus attended to you should carefully an-
 pimented the nurse while she is washing it. She should rub
 it over with warm water, if any of the sebaceous matter be
 very adherent you may use mild animal oils, or soap which
 is not very alkaline. After the washing the child should be
 carefully dried, there is no objection to the use of powder
 as it assists the drying. — After the cord is cut it lies up to
 the skin of the child's abdomen, ^{if exposed to air} dries & suppurates at the place
 of junction & sloughs off in from 3 to 5 or 7 days. Hence the cus-
 om of covering the cord in civilized life is justifiable in
 stead of drying, & if allowed to lay in contact with the abdomen
 may cause some trouble by the irritation it produces. It should
 therefore be dropped, by enveloping it in a piece of cloth,
 through the centre of which the hole is cut for its reception, &
 the cord placed with its end upwards, several folds be-
 ing interposed between it & the child's skin. A belly band
 should be applied round the child's body to keep the dres-
 sings of the cord in situ. This band should not be allowed
 to be drawn tightly, since it may impede respiration. The
 popular notion that it will prevent the belly from swell-
 ing & the naval from protruding is incorrect & should not
 be encouraged. It should be made of flannel; this however
 is not important. The mode of dress may be after the par-
 ticular fashions of the times or the taste of those concerned,
 provided it be warm & not so tight as to impede respira-
 tion & the free circulation of the blood. No first impressions
 are always important, the child should not be presented to
 the mother until it is dropped. You may allow it to feed from
 the mother's breast, or if that be not practicable, at once

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sugar & water should be given to the child. Molasses & water are more apt to sour. The various little 'nice' things prepared by nurses & old women should be rejected.

Lecture XXXIII, January 27th

Sometimes the compressed state of the head will continue for a length of time after birth, the head being in most instances very much elongated. The best plan is to let it alone. Be careful that the nurses & other very meddling persons, do not attempt to correct this by compressing the head. This interference often gives rise to inflammation of the brain & all its serious consequences. — As soon as the child is in a condition which will allow it to be laid aside you should attend to the mother. After the delivery of the placenta, in the higher walks of life, ^{more than any other} the mother, will often be very much exhausted. They generally perspire profusely. The perspiration should be wiped off so that the patient shall be perfectly dry. The binder should then be applied. The advantages of it are, 1st there is always a feeling of emptiness & exhaustion followed in many instances by syncope which is prevented by compression properly made, 2nd it is necessary that the uterus be fixed, the falling of it into the lumbar regions on either side being productive of such a state as to favor hemorrhage, ~~that~~ ^{it} is most apt to fall into the left lumbar region from the woman's laying on the left side. 3rdly, a moderate degree of compression keeps up the tonic contractions of the womb. 4thly women who have had children previously are liable to pendulous abdomens. It is objected to the binder by some, that it is often ^{im}properly applied. But this is an objection to the ~~proper use of any~~ ^{use of any} which is not worth a consideration, since all of our efforts are liable to be foiled by this failure of those concerned to carry out our suggestions. We only recommend it when properly applied. Again it is said that by it the intestines are forced down into the iliac regions & give rise to hernia. But the bandage should not be too tightly put on. Ordinarily a towel is used for this purpose. It should

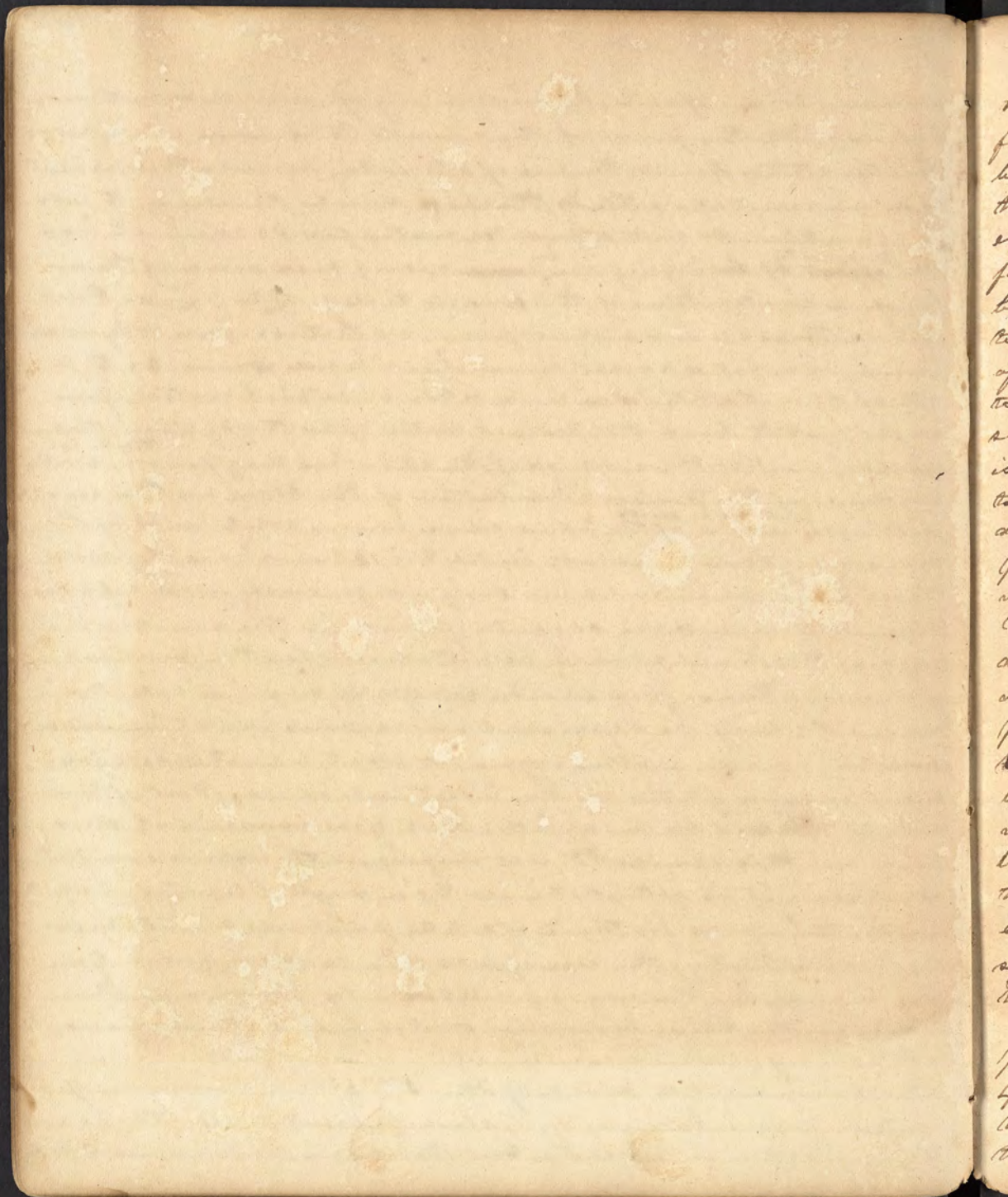
* Under the binder I am in the habit of placing ^{broad} ~~exposed~~ ^{exposed} gauze & prep, over the regions of the wounds. It has the advantage of keeping pressing the intestines down in the lumbar & iliac regions, on each side of the wounds, so as to keep it in the middle of the abdomen, & not as some say by mechanical pressure exciting the tonic contractions.

be of considerable breadth, & be put round the hips below the
 the abdomen above. Sometimes in the niger ranks you may direct
 a binder to be made, having such a form as to fit these parts. It
 should be long on its upper margin than below, & having hooks
 at one end and islet holes at the other arranged in rows, so that
 it may be tightened or loosened according to the sensation of
 the patient. After the external organs have been well dried
 a napkin should be placed against the pelvis to absorb the
 lochia. It should not be secured there by a bandage because
 it is important that the evagulation of blood be not prevented
 from coming out. After these measures have been resorted
 to the patient may generally be moved to the other part of the
 bed. I have found that while she is under this pleasant state
 of mental excitement before spoken of she may be more readily
 moved than afterwards. If there be a disposition to hemorrhage
 or if she be very much exhausted & disposed to agree
 she may be allowed to remain for some until the
 proper remedies be applied. She should be moved cautiously
 say. She should not be permitted to make any muscular
 exertion not even to raise up her head, during this opera-
 tion, but should be gently slid down by assistants suffi-
 cient in number to accomplish it without any difficulty.
 I prefer that she should lay on her back as this position
 least of all favours hemorrhage. If she become impatient
 of this position she may after a time upon being carefully
 watched be allowed to turn from side to side cautiously.
 It is generally desirable that she should be permitted to
 sleep, & to effect this it is necessary that every thing cal-
 culated to excite should be avoided. She should
 be permitted to see no company, One or two of her nearest
 relatives should may be allowed to see her, yet cannot
 be too cautious in this point. The room should be dark-
 nessed. When sleep does not come on early you may

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administer an opiate. Opium in my opinion does not in-
terfere with the power of the womb to remain in a con-
tracted state. Avoid the use of stimuli, because the patient
is in an irritable state & there is much tendency to in-
flammation. Do not allow ice water for I believe it has
the ~~effect~~ ^{property} of bringing on ~~in~~ many cases some of those
painful contractions of the womb called after pains. Ad-
minister as above stated opium, or Lactucarium or Hyoscin-
amus, or what is a great favourite with me ~~opium~~ 30 to 60
grs of Spirit. Mt. Dore in a little sweetened water. You
ought not to leave the patient until after the system has
reacted, until the redness of the skin has disappeared, and
evidence of the proper circulation of the blood in the ac-
quiescence. ^{before the contractions} The after pains come on in 1 or 2 hours after
delivery or sometimes not until 8 or 12 hours have elapsed.
Those pains which come on early are generally more severe.
When they depend on coagula of blood in the womb or
vagina the hand should be introduced for the purpose
of removing them. You should carefully enquire into the
cause. It may be dependent on nervous irritation, upon
irritation in some other organ, or mental emotions, or fre-
quent cause is flatulency in the intestinal canal. Most of these
may be relieved by an opiate. But you should not de-
pend on this alone. Do not infrequently depend on Plecte-
ora; hence it is often relieved by a single bleeding. Do not
mistake these pains for those of eclampsia, peritonitis & metritis, for
the mode of treating the case would then be very different. You
may do much in the way of prevention by procuring the
uterine contractions, removing irritations in other organs,
& by avoiding mental excitement.

We come now to speak of the 2nd grand division of
natural presentations, viz Prolapsed presentations. They were
formerly called unnatural, but there can be no doubt but



that most of them can be delivered by the unaided efforts of the mother. The study of them is very important because more difficulties may arise from interference than in any others. They are more dangerous to the mother & the child than the ~~vertex~~ presentations. They are unfavourable to the mother because in the first stage of labour, there not being as large a portion of the child presented, the dilatation does not take place so rapidly, the bag of waters is not as large, & bursts before ^{the child is} it is large enough to permit the rapid delivery of the child; & in the second stage the passage of the child being much slower, there is a greater amount of physical exertion required in order to complete the delivery. They are dangerous to the child because during the second stage, it is more liable to be fatally compressed both as regards the cord & the delay of respiration, while the head is within & the body within the uterus. They have been divided into regular, & irregular according as the oblique axis of the foetus elapses, or the knee or the feet are presented. The mechanism of feet & knee presentations are essentially the same as breech presentations, & by thoroughly studying that of the one you will be able easily to comprehend that of the others. I see no reason why we may not have 6 positions of the breech as well as of the vertex. The first is where the sacrum is towards the left acetabulum of the mother or the back part of the thighs to the right sacro-iliac symphysis. 2nd position Sacrum at the right acetabulum the back of the thighs at the left sacro-iliac symphysis. 3rd position. Sacrum at the symphysis pubis & back part of the thighs at the promontory of the sacrum. 4th position, the reverse of the 3rd, the back of the thighs lying at the left acetabulum & the sacrum at the right sacro-iliac symphysis. 5th position the

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reverse of the 2nd, the back of the thighs being at the right acetabulum & the sacrum at the left sacro-iliac symphysis. 6th position, the reverse of the 3rd, the back of the thighs at the symphysis pubis & the sacrum at the promontory of the sacrum. — A fundamental principle in the study of the mechanism of these presentations, is that upon the rupture of the membranes the foetal ellipse is made more compact, instead of being as represented in the works on obstetrics lengthened by the feet being stretched out. Mechanism of the first position. This is with some modifications essentially that of the other positions. From the mechanical consideration already spoken of the pelvis does not so soon pass into the cavity of the maternal pelvis after the rupture of the ^{membranes}, so soon as in vertex presentations. This thing place however the hips rotate upon the inclined planes, the left hip is thrown under the arch of the pubis, the right hip being towards the sacryx. There being no twist in the loins, when they are delivered restitution takes place. The arms should pass before the head. The shoulders rotating on the inclined planes, the left shoulder is thrown under the arch of the pubis, the right being towards the sacryx. The head is still oblique. The shoulders being delivered restitution takes place. The delivery of the head being next in order, the hour having expired & there being much important detail on this subject, I will defer its consideration until the next lecture.

Lecture XXXIV. February 1st 1843.

We now speak of the delivery of the head. The chin being downwards with respect to the mother, it will enter the superior strait before any other part of the head. The anterior fontanelle engages at the superior strait opposite the right sacro-iliac symphysis, & the nape of the neck to the left acetabulum. Hence the occipito-breg-

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly obscured by fading and stains.]

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matic diameter corresponds to the oblique diameter extending from the
 left acetabulum to the right sacro-iliac symphysis, while the biparietal
 corresponds to the other oblique diameter; & the occipito-mental cor-
 responds to the axis of superior strait. Should the chin depart from
 the breast, we would have instead of the occipito-bregmatic, the
 occipito-frontal diameter engaged, & the departure being increased
 the occipito-mental. Traction effort will cause this departure. The
 measurements of the diameters will show at once the improprie-
 ty of such interference. The chin descending into the cavity of the
 pelvis first, the occiput rotates on the left anterior inclined
 plane & forehead on the right posterior, the face is pushed into
 the hollow of the sacrum. The whole of the child being now out
 of the cavity of the uterus, we must depend on the bearing
 down efforts to cause the passage of the head through the in-
 ferior strait. The head engages in this strait having the bipari-
 etal diameter corresponding to the transverse, the occipito-breg-
 matic to the antero-posterior & the occipito-mental to the axis.
 The head may be arrested by the cessation of its flexion, the occipito-
 mental corresponding to the ant-posterior diameter will cause de-
 lay here; in fact there will be an impossibility of delivery in
 most cases. The occipito-mental corresponding to the ant-
 ro-posterior diameter renders the delivery absolutely impossible.
 To prevent these inconveniences, we throw the body forward.
 The diagnosis of breech presentations is generally easy, to one ex-
 perience in the feel of the parts. The anatomical peculiarities
 must be our guides. I have found that the ilium the accyp &
 the sacrum will enable me to diagnose most surely.
 The discharge of meconium is not an infallible sign. It
 is most apt to occur in these presentations but may take
 place from any. — The details of the first presentation will
 render it unnecessary to dwell long on the others. In the 2nd po-
 sition, the mechanism is the same as first in essential points. Rotation
 of the hips & shoulders ~~which~~ takes place on the left anterior &

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the right posterior inclined planes. Hence the right shoulder ~~is~~ ^{comes} out under the arch of the pubis. The head rotates on right anterior & left posterior inclined planes, & comes out as before.

The 3^d position is by most authors considered the most common of the pelvic presentations. The reasons for this are that the transverse diameter of the thighs is most easily accommodated in this direction, & that being in this direction it is not easily changed, because the interstices between the thighs is well adapted to the promontory of the sacrum. The hips are rarely delivered transversely. Should they rotate into the position which would make their transverse diameter correspond to the antero-posterior diameter of the inferior strait the twist in the lins will be greater. Restitution takes place transversely. The shoulder may then be delivered transversely or antero-posteriorly. The head does not rotate; & the delivery of it at the inferior strait is the same with the 1st & second positions. Difficulty may occur at the superior strait, from the ~~head~~ ^{child} departing from the breast, & causing the occipito-mental diameter to correspond to the antero-posterior.

— The sacro-posterior positions are not so favorable as the anterior, because it is more difficult to keep up the flexion of the head to that extent necessary to a safe delivery. In the fourth position rotation taking place the right hip comes out under the arch of the pubis; restitution taking place, the right hip is towards the right groin. The shoulders rotating, the right one is delivered under the arch of the pubis. The head rotating, the occiput is thrown into the hollow of the sacrum, & the anterior part well under the arch of the pubis. The back of the shoulder being towards the sacrum, there is rather more than the occipito-bregmatic diameter antero-posteriorly at the inferior strait, & ~~then~~ ^{there} the delivery is more difficult. There are three the occipito-bregmatic diameter corresponding to the antero-posterior, the biparietal to the bischismatic & the occipito-mental to the axis. It is often difficult to present these diameters to the

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inferior strait on account of the relation of the shoulders to the
 perineum; the perineum having a tendency to throw the fore-
 head, ~~the~~ ^{the} chin behind the pubis; & the fact that the top of the
 head does not fit well in the arch of pubis, thereby caus-
 ing a loss of room. - Sometimes nature effects rotations in an
 opposite direction, thus making the delivery of the head the
 same with that in the 2nd position. Thus, instead of the ver-
 tebra rotating on the right posterior, it rotates on the right
 anterior inclined plane & is thrown under the arch of the
 pubis. - 5th position is essentially the same as the 4th. The
 left hip & left shoulder come out under the arch of pubis.
 The occiput rotates upon the left posterior inclined plane & is
 thrown into the hollow of the sacrum & delivered as in the
 4th position. - 6th position is the source of some trouble at the
 superior strait in many cases, as regards the passage of the
 head. It is generally converted into the 4th or 5th position.
 & the mechanism will vary accordingly. - You will oc-
 casionally have feet presentations. The mechanism as be-
 fore state is the same as pelvic presentations. There are six
 positions of the feet. The 1st is when the heels are at the
 left acetabulum, The 2nd when the heels are at the right
 acetabulum, The 3^d when they are at the symphysis pubis.
 The 4th when the spines of the tibiae are at the
 left acetabulum, The 5th when they are at the right
 acetabulum, The 6th when they are at the symphy-
 sis pubis. Each of them corresponds to the same pro-
 ce~~ssion~~ of the breech as to their mechanisms. - The fol-
 lowing are the positions of knee presentations. viz. 1st when
 the spines of the tibiae are at the left acetabulum, 2nd
 when they are at the right acetabulum, 3^d when they
 are at the symphysis pubis, 4th when the front of
 the thighs are at the left acetabulum, 5th when they
 are at the right acetabulum & 6th when they are

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at the symphysis pubis. — For the same reason that
pelvic presentations are unfavourable as regards delay,
the knee presentations are more unfavourable than the
pelvic, & the feet more ~~and~~ than those of the knees.

Lecture XXXV. February 3rd '43.

We come now to the treatment or rather management of pelvic pre-
sentations. The same general directions as to the management of
vertex presentations will apply to these. — In general you can tell ^{early}
during the dilatation of the os uteri that the pelvis is coming
down. Bear in mind that there are natural presentations, that
the woman by her own unaided efforts can deliver herself, &
that ~~at~~ although this be true, complications are more apt
to arise than in the others. Hence be on the alert to see that
the proper changes occur, & as it is important that the second
stage of labour should in these cases be as short as possible,
judiciously facilitate those changes. — It is important that
the os uteri should be fully dilated, before the second stage
commences. Hence prolong the first stage ~~in~~ avoid any
thing which may cause rupture of membranes. Do not al-
low the patient to be up, make her lie down, request her to
avoid bearing down efforts, avoid any effort in evacuating
feces, if there be a desire to pass urine use the catheter,
should there be great disposition to sneeze or cough use some
mild anodyne. As soon as the membranes are ruptured re-
quest the patient to make bearing down efforts, do not make
traction effort by hooking the finger in the grove of the
child, but rather prevent for a time the outward progress
of the child by pressing the finger against the pelvis, to in-
crease the form of the foetal ellipse. Do this with judgement,
for incautious, done you may produce rupture of the uter-
us. The hips descending into the cavity of the pelvis you may fa-
cilitate rotation by hooking the hips with the fingers, when they
come to the inferior strait, take care of the perineum, press

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it forward. By doing this you increase the lateral flexion of the child's body & thus better accommodate it ~~to~~ the canal of the pelvis through which it has to pass. The legs may now be unfolded, taking care that the perineum sustain no injury. Do not interfere as to respiration. Avoid traction effort. The ill consequences are 1st that the arms are thrown up, & 2nd that the chin may depart from the breast, & cause the engagement of the long instead of the short diameter of the head. — Request the patient now to make bearing down efforts during a pain. The shoulders now pressing the superior strait & coming to the floor of the pelvis ought to rotate. Rotation may be facilitated by placing one finger on the occiput of one side of the child, & another finger in front of the shoulder of the other, or if two fingers cannot be introduced one may suffice. After rotation you may hook the elbows by means of your fingers & bring the arms down, or doing so be cautious not to make traction effort on the body of the child. Examine now the condition of the cord. If its pulsations if feeble or has entirely ceased, it is probably pressed upon by the child's head. This being the case follow it up to the point of pressure & remove it to where it may have more room. The shoulders being delivered you will generally find that foetal existence has ceased. Therefore it is important that the head be delivered speedily. The rotation of the head may be facilitated. The head being now out of the cavity of the uterus the woman must make strong bearing down efforts. Throw the body of the child forwards, request an assistant who is strong & worthy to make traction effort in the direction perpendicular to the patient's body, support the perineum, pass one finger into the rectum, & through the recto-vaginal partition ~~and~~ on the child's head so as to draw it down to

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wards the breast. Your recommendation that the perineum be cautiously pushed away from the mouth & nostrils of the child so as to permit breathing. In some cases it is important to do so, but generally I have found that the proper use of the means already recommended will accomplish the delivery sufficiently soon. - The remarks already made will apply equally to the 1st or 2nd positions. - In the 3rd position, the hips & shoulders generally rotate spontaneously, & come out of the inferior strait with their transverse diameter antero-posteriorly. The head also will almost always rotate. Not doing so difficulties may arise, & consequent upon a disengagement of the child from the breast. Panchetagne was wrong in recommending action upon the body to change the position of the head at the superior strait. - The peculiarities of the 4th position occur when the head is at the inferior strait. By acting on the face of the child you may in many instances cause rotation to take place in an opposite direction, so as to throw the occiput under the arch of the pubis. Should it be impossible to convert the position of the head ~~into~~ into 2nd position, you must throw the body backwards & make traction in a direction perpendicular to the mother's body, taking care of the perineum, & giving proper direction to the occipito-mental diameter by pressing with the fingers upon the forehead. The fifth position may be converted into the first, not being able to do this the management is the same with the last. In the 6th position, from the convexities of the occiput & the promontory of the sacrum ^{is} ~~may~~ almost always be converted into a fifth or fourth with out assistance. Should this not take place you may easily produce it by operating on the chin. - In fault presentations the indication is to prevent rupture of the membranes before the full dilatation of the os uteri. Therefore

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Keep the feet back until dilatation is fully accomplished, taking care not to persevere too long, there being a liability to rupture of the uterus. After the os uteri has embraced the body of the child there is no objection to drawing down the feet. - Presentations are exceedingly rare. It is very difficult for the feet to so far depart from their position in the perfect foetal ellipsis as to come behind the body of the child. When they occur bear in mind that it is important that the os uteri be fully dilated before the second stage of labour commences. In other respects feet & breech presentations are managed in the same manner as those of the breech.

It should be borne in mind in the practice of obstetrics that the more valuable life of the mother is not to be sacrificed for that of the child. Yet if a man have any science, how much must he suffer if through ^{of this pro-} ignorance ^{fession} he unnecessarily sacrifice the life of an infant. Having now finished the subject of natural labours we come to speak of complicated ones. Although they are ~~very~~ rare, you should not think it unnecessary to study them. For you must know how to manage them when they do occur. A perfect familiarity with them may be the means of saving life in many instances, & an ignorance of them the cause of disgraceful consequences. - Complicated labours may arise 1st from mal-presentations, 2nd from deformities of the mother or the child, 3^d from mal-positions of the uterus, 4th from physiological states of the uterus, as rigidity & relaxation & 5th from disease & its consequences, as inflammation of uterus, accotrices, or prolapsus of the ovary, & general diseases as convulsions &c.

Lecture XXXVI February 15th 43.

As regards physiological & pathological conditions which produce complications, much depends on general means. What are called medical means will be mentioned under the head.

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of the particular complications in which they are resorted to. Complicated labours have been divided into manual & instrumental. This division is rather indefinite, for what one accoucheur would do with the hand another would do with instruments. Again the same accoucheur would be compelled to resort to the instruments, where in another similar case he would be able to accomplish the delivery without assistance other than his hands. Still there are cases in which a resort to instruments is absolutely necessary, also some in which the hand is fully adequate for the end in view, & the resort to instruments unnecessary. Hence though not mathematically correct we will use these terms for convenience. — By manual labours we mean those in which by the hands alone we produce such changes in the position of the child as do not follow from the natural passage of ^{it} the child during its progress of delivery. In other words when with the hand we change the character of the labour. — When we change the character of the labour by instruments we speak of instrumental labours. These labours are of three kinds viz, 1st those in which neither the mother nor the child are injured by the instruments. 2nd in which the child is injured for the purpose of saving the mother & 3^d in which the mother is injured for her own safety & that of the child. — It must be borne in mind that in all these cases the mother's life is not to be sacrificed for that of the child. — We speak then first of versions. This is dangerous to the mother because it is painful. And as pain is ^{not} ~~injurious~~ physiologically it is injurious. There is danger of injuring the uterus, as by lacerations, contusions or ruptures. Version by the feet is dangerous, as in addition to the objection of artificial labour, the delivery as already stated are not as favourable as vertical. Besides these there is danger of loss of the child. The first rule which I will lay down is, that you carefully estimate the difficulties to be overcome, & if they are great enough to overbalance the dangers of the operation, compare the several operations proposed

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for relief with each other. 2^{ndly} as your reputation will depend on the result of your conclusions, as young practitioner it is your duty if possible to call a consultant. Unfortunately there is not often time for this. - 3^{rdly}, advise the friends of the patient fully concerning, & make known to herself the necessity of your course, in such a manner as not to create unnecessary alarm. 4^{thly} never think of it unless the presenting part of the child is within the cavity of the uterus. The cavity of the organ is contracted to too small an extent a cavity to allow the os uteri within it; & the part without will present mechanical difficulties which are at once evident upon consideration. 5^{thly} never as a general rule think of it unless the os uteri is dilated or dilatable. Some have performed it under opposite circumstances, & indeed it may become necessary. I will however remark that I have never done it myself. - I think the patient had best be placed on her back in all obstetric operations. For as a general rule it is more convenient to the practitioner; the pelvis is fixed, thus giving you a better opportunity to ascertain the precise position of the child, you wish the uterus supported in one position, you wish to be able to place ~~the~~ hand on the fundus while you are operating with the other. The hips should be brought to the edge of the bed for you cannot introduce the hand sufficiently far in. Some cases, on account of the resistance which the bed will cause against the elbow, if they be far up on it. Support the hips upon something so that the thighs shall be flexed upon the pelvis. An assistant should hold the knees apart. The practitioner should sit on a chair, stand up, or kneel, & if necessary sit upon the floor, according as it is convenient, between the legs of the patient. He should have some anastomous assistant with which to cover the hand to be introduced, all things which may be necessary for the resuscitation of the child should it be borne in an as-

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phryiated or asthenic state, as warm bath, stimulants, cold wa-
 ter &c, in readiness. He should take off his coat with as little
 parade as possible. If convenient he may put on a night
 gown or loose wrapper, the sleeves of which can be so rolled
 up as ~~not~~ to interfere with the freedom of the motion of
 the arms. — The back of the hand & ^{the} arm to be used ~~must~~
 should be anointed. The anointing of the palm is un-
 necessary & is ~~indeed~~ rather a disadvantage since ~~it~~ does
 not come in contact with the mother's parts, but with
 the child. — Of version by the head. This is necessary and
 advisable in those cases which do not call for a speedy de-
 livery, & when the side of the head or a portion of the neck
 or a part of the shoulder presents. Suppose a case in which
 the side of the head presents, and is a deviation from the
 first position of the vertex. As to the choice of hands, I will
 say, that if you will fix in your mind the precise posi-
 tions of the child, & consider the object to be accomplished
 you will have no difficulty. In this case the right hand
 is to be used. It should be in a state of semipronation.
 Four motives of delicacy enter the vagina during a pain.
 Pass in finger of ^{or} finger ~~then~~ the ~~stimulus~~. They should
 enter in a conical form, when all are within the vul-
 va, in the direction of the axis of the inferior strait.
 Remember that the stretching is to take place ~~in~~ the per-
 vium. When the hand has entered the vagina it should
 be put in a state of pronation. This brings it in the axis
 of the superior strait. Push the presenting part up out
 of the superior strait. Carry it to the right side. With
 the other hand push the ^{fundus of the uterus} ~~up~~ to the opposite side. Slough
 ing the fingers over the os, pull it down wards. The pain
 is now in your favour, & will probably effect what other
 changes you may desire. The version in other deviations
 is conducted on the same principles. The deviation

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from the 2nd position will require the introduction of the left hand. - Version by the feet is performed when the delivery must be effected rapidly. Advise the friends of the necessity of the case & tell the patient as before. That hand which in semi-pronation will correspond to the front of the child must be used. Carry the hand in; the fingers being towards the sacrum then be towards the pubis, if it be a case of ^{first} position, push the child's head to the left, with the right hand push the fundus up the uterus to the right, during the absence of a pain push the hand along the side of the body of the child, coming to the groin you will be able to find the feet, pull them down & bring them to the superior strait as in 2nd position & rotate in 4th. This must be done not during the pains, but during the relaxed state of the uterus. The child is then to be delivered as in 2nd position. If circumstances will not allow of leaving the case to nature traction must be resorted to. Of this I will speak at the next lectures.

Lecture XXXVII. February 8th 1831.

The uterus acting powerfully the necessity of traction effort may be superseded. Traction should be made in the direction of the axis of the superior strait, as there is danger from displacement of the arms, & when you should if possible only make traction during a pain, and as in most cases you can have the advantage of bearing down efforts you should call them into requisition. You must facilitate rotation of the hips. After the hips pass out of the vulva suspend your efforts. See that the arms are not misplaced. Should they be misplaced, by passing the fingers on the side towards the sacrum & push down the dorsal shoulder first and then with the fingers on the pubic side push down the pubic shoulder. Rotation

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tion of shoulders should occur. Traction should now be cau-
 tionally made during a pain or during bearing down efforts.
 After delivery of shoulder cease your traction efforts, ~~and~~ act
 on the upper maxillary bone with a finger on each side
 of the nose to prevent the chin from separating from the
 breast. This not succeeding you may carry the fingers up ~~on~~
~~for~~ the ~~inner~~ side of alveolae & push the occiput upwards.
 You may assist rotation by acting on the chin or occiput
 or both. When the head has descended you may carry
 the body forwards, let an assistant make traction in
 a perpendicular direction, while you act on the head
 as directed in the lecture on the delivery of presentations of
 the breech. When you can only get hold of one foot you may
 make version with it so as to bring it out, being care full to
 keep it in its proper plane, i.e. not to twist it. When it is
 brought down secure it with the fillet, while you reach
 for the other foot. The first stage of labour should be
 concluded before you attempt this version; ~~it~~ is best to
 carry the hand in before the rupture of the membranes,
 & accomplish this ^{version} ~~delivery~~ before the uterus has contrac-
 ted upon the child. The directions for version in the
 other positions of the vertex are the same with some mod-
 ifications. In version from the 2nd position of the
 vertex you bring down the feet in the 1st. From the
 4th bring them to the 1st, from 5th to 2nd. If you
 make version from the 3rd position, if you use
 the right hand you bring the feet down in the 1st
 position, if the right hand the 2nd position. In
 the 5th position if you use the right hand you will
 bring the feet in the 1st position, if left hand in the
 2nd position. — As to, hasten delivery in breech presenta-
 tions, it is better to see the hand, than to resort to instru-
 ments if possible, It is better to bring down the feet than

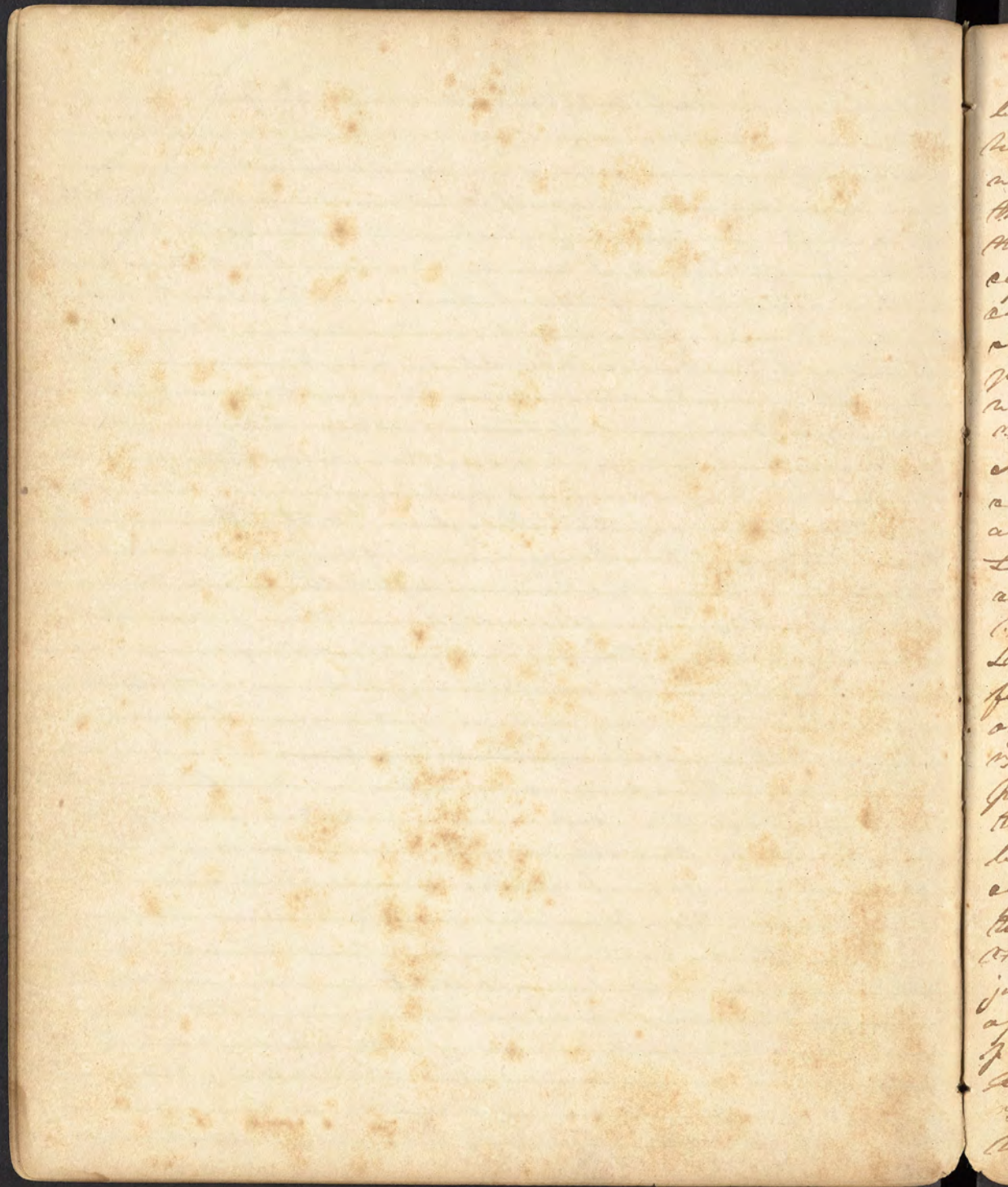
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to act on the breech if possible. In the first position you will use the right hand, in the second the left hand, the 4th the right hand, & the 5th the left hand, & in the 3rd or 6th ~~the~~ ^{either} hand. It should be borne in mind that in these cases the toes & not the heels are in the palm of the hand. Deviations from the natural presentation of the osseous end of the fetal ellipse often correct themselves without assistance. The finger will almost always rectify them at any rate. — Should you not be able to bring down the ~~breech~~ feet & it is immediately necessary that the traction efforts be made you may accomplish much with the fingers, alone. Instruments are used for this purpose. Of these instruments the simplest is the fillet which is introduced from the pubic side of the child & after embracing the pubic thigh is brought down ~~from~~ between the two thighs. Traction effort may be made with this while the other groin is pulled down with the finger. The blunt hook is to be carefully applied when used so that the point of it cannot injure the thigh of the child. When used it should be heated to the temperature of the mother's body in ~~part~~ ^{part} ~~assumes~~ ^{as} warm water, & the plane of the hook should correspond to the ^{long} ~~axis~~ ^{long axis} of the body and when introduced, if the object be to put it around the pubic groin the handle should be depressed at first & then raised in the opposite direction, When over the sacral ~~thigh~~, you should ~~raise~~ ^{raise} the handle at first & then depress it. The fillet may often be passed by the aid of Bell's instrument. — In all cases the object of ~~the~~ the use of the instruments should be made known to the patient ~~as~~ to her friends.

8 5

Lecture XXVIII. February 10th '43

It was about the year 1718 that the forceps were introduced. There have been disputes amongst Physicians concerning the propriety of first introducing them to the notice of the profession, whether it belongs to the French or to the English. I am of opinion that it belongs to the latter. Dr. Chamberlain was the first to introduce them. (He lived in London). The forceps consist of two blades, called male & female. The male blade is introduced on the left side & the female on the right of the mother. They are then forced by corresponding hands of the practitioner. There are various modes of connecting them viz. the German the English, & the French. Of these I think the German is the best. The shafts should be so long that when operating at the superior strait you will not have the pivot so near the parts of the mother as that they may be injured by it. The two arms should be so fitted to each other that no rocking motion can be communicated to them ~~when they are together~~ ^{at their pivot}. The blades should have two curves viz a curve to fit the child's head, called the cephalic curve, & a curve to correspond to the curve of the pelvis called the pelvic curve. The fenestra should be so large as to permit the parietal protuberances to lodge through them so that the bi-parietal diameter of the child's head shall not be increased by the forceps. There are few cases in which the forceps are to be applied in any other direction than that of the occipito-mental diameter. They are sometimes though rarely used so as to embrace the forehead & the occiput. The handles should



be so hurt at their extremities as to answer for a blunt
 hook. — Smellie's forceps (among the first of the English)
 were too short, had only the cephalic curve, & had
 the blades bound with calf skin to prevent injuring
 the child's head, which was quite unnecessary had the
 cephalic curve been properly made. Osbourne's for-
 ceps were the next; they were short, had the double
 curve, & the English, & dispensed with the wrap-
 ping of calf skin. Brighton's forceps which were
 most approved by Dr. James our former professor.
 They were a modification of Osbourne's, & were
 characterized by great breadth of blade. Davis' for-
 ceps are the best specimen of English forceps. They
 are used by Dr. C. D. Meigs. — Of the French forceps
 Lescault's is the first specimen. They had a double
 curve, a small ridge around the fenestra, & the
 French lock. Baudeloque's which were used by
 Dr. Osbourne, did not have the ridge around the
 fenestra & the fenestra were wider. The locking is
 objectionable. The German forceps are too short,
 the German lock is the best. Rorer's Philadel-
 phia forceps too light for some of the operations.
 The blades are not sufficiently long. Rorer is the
 best forceps maker in Philadelphia. The for-
 ceps of which I most approve are a modifica-
 tion of Baudeloque's having the German pivot.
 Forceps if properly managed should not be in-
 jurious to the mother; for the more power you
 apply to them the farther you are from their
 parts. The danger to the child depends on the
 length of time the head is overpowered & how much.
 The forceps are necessary when the woman
 has not power to expell the child. — Suppose

[Faint handwritten notes, possibly bleed-through from the reverse side.]

the head down in the inferior strait & delivery by the forceps is necessary. The male blade is then in the left hand & introduced into the vagina the soft parts of the mother being protected by the fingers of the right hand on the vent side of the blade. The end of the blade should be made to push against the head of the child. The handle should be elevated at first & as it proceeds inwards, depressed & when it has fully embraced the sides of the head the parietal protuberances being within the fenestra, the handle should then be held by an assistant & if it do not remain in situ without. The female blade must then be taken in the right hand & introduced as the other. If the two blades do not lock together easily no force should be used to make them do so. Their coming together with ease is an evidence of the two corresponding sides of the head being embraced. If it be necessary to withdraw the blade it should be withdrawn in a manner just the reverse of that in which it was introduced. To ascertain whether you are injuring the mother you should ask her if she feels any pain at the same time that you make some effort. If you ask if you hurt her she is sure to answer in the affirmative. The rectum or liver is more apt to hurt the mother than the uterus.

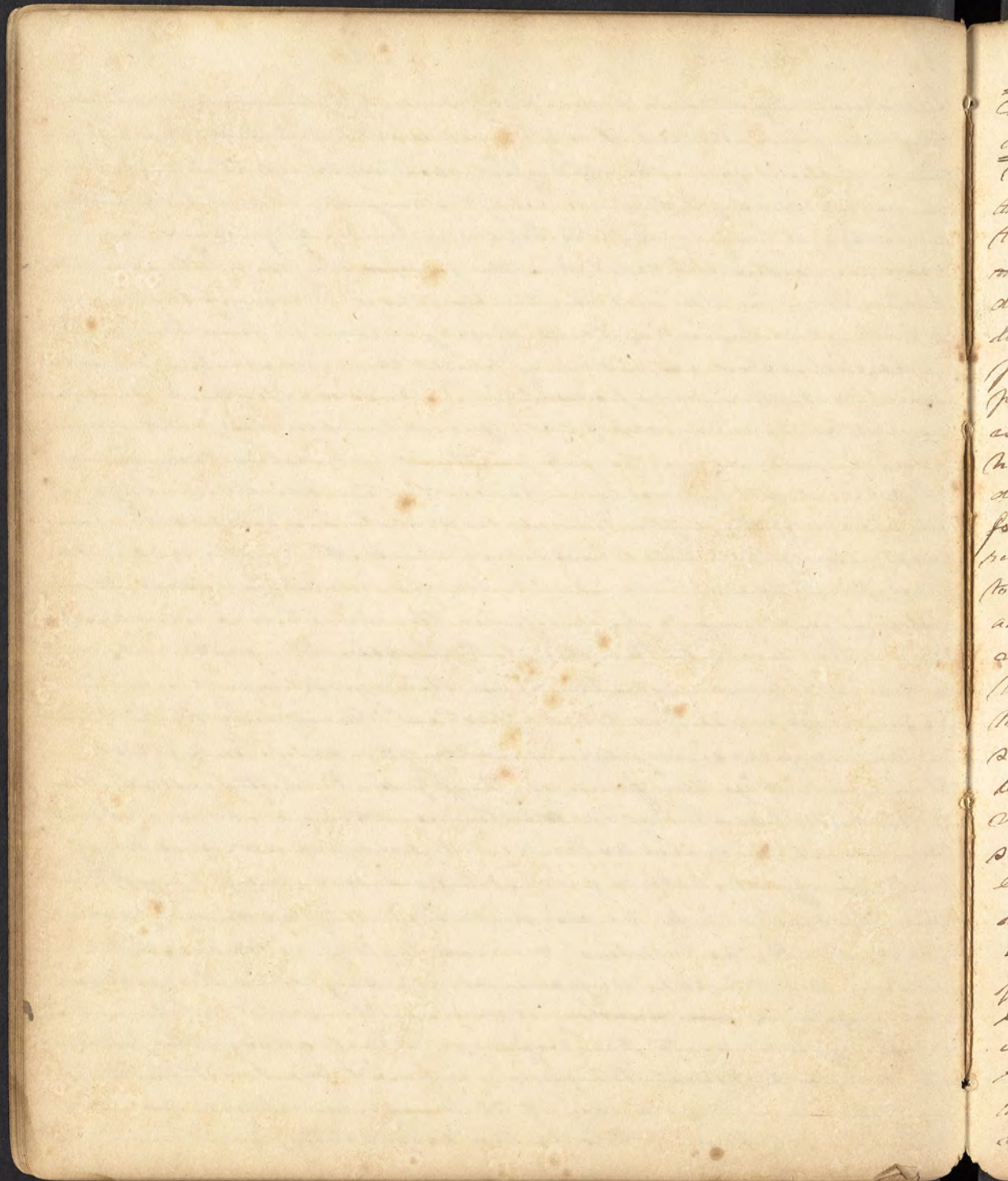
Lecture XXXIX. February 13th '43.

I think that much more injury has resulted from delaying to apply the forceps, than from their actual application. The child may press upon the soft parts of the mother, causing inflammation & abscessing. The circulation may be cut off & thus more

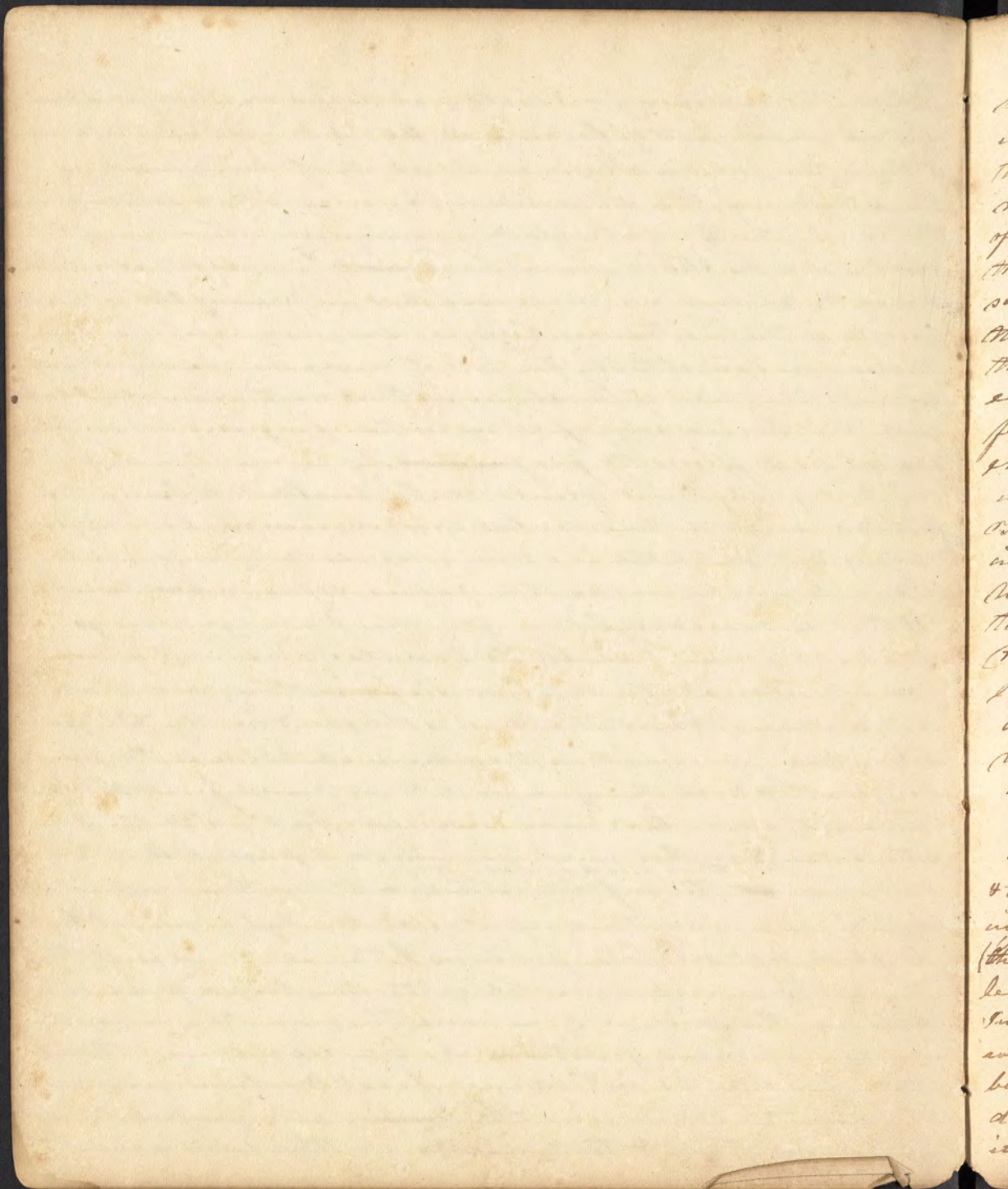
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tification may at once ensue. The opening of the bladder may thus take place; indeed, it is oftener caused by pressure than by the incautious application of the forceps. These things should be borne in mind since practitioners are often unjustly blamed. Yet they should not be perverted to the concealment of ignorance.

When the head is included within the forceps the parietal protuberances being in the fenestra, the shanks will always be found a little above the level of the anterior fontanel in the case supposed in the last lecture. — It may be well enough to remark here that the forceps are compressors. If the head be not completely ossified, you can sometimes gain even as much as 6 lines in the biparietal diameter. Hence it is always best to have the most diverging portions of the cephalic curves about 2½ inches from each other when the blades are shut. The forceps are also tractors. It should be borne in mind that the traction is always to be made in the direction which will cause the head of the child to pass in the natural direction. Always make traction during a pain. When the pain ceases cease traction effort. — When it is wished to make compression permanently you may use a fillet bound round in the form of the figure 8 at the extremities of the handles. — They are also levers. Bear in mind that they must be used as levers while you are making traction effort. — As a general rule we may say that the forceps are to be used moderately as compressors, powerfully as tractors, & anoderately as levers. — Following out the case supposed, we say after the forceps are applied ~~in order~~ draw in the natural direction when you come to the inferior strait allow the forceps to rise & support the perineum. Some direct that the forceps be withdrawn at the inferior strait, but for obvious reasons this is no easy matter.



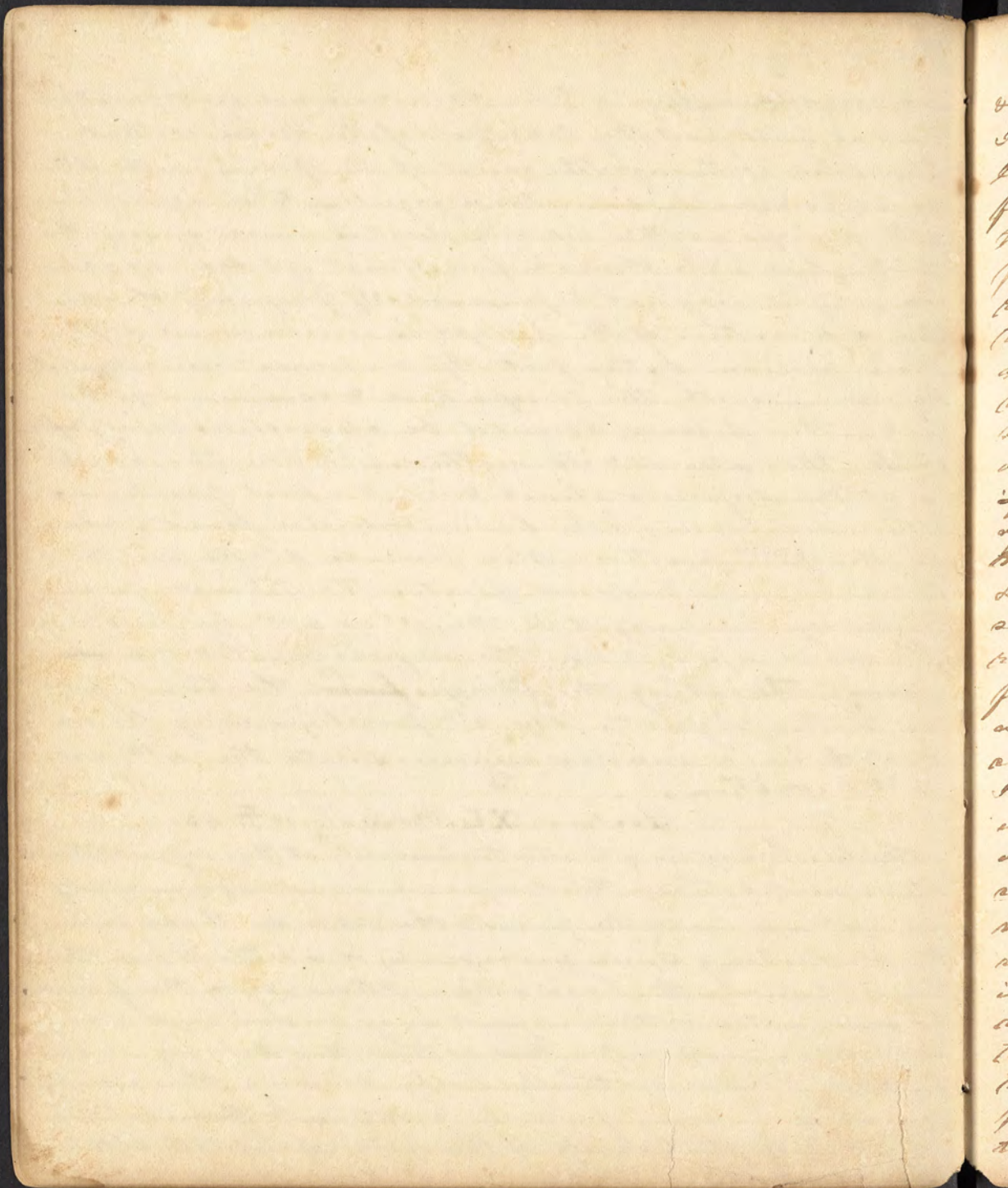
When the anterior fontanel is at the pubis the handles will be allowed to go backwards ~~the~~ extension takes place.
When the head is oblique in the cavity of the pelvis & in the situation of the 1st position the male blade is the posterior, & the female blade anterior. In introducing the ~~male~~ blades the ~~blades~~ must be ^{carefully} separated. In introducing the male blade remember that in passing the in that handle of the instrument must be very rapidly depressed in order that the point may be constantly applied to the head of the child. - Pass in the female blade with the lower edge of it upon the fingers, & when it has got in sufficiently far ~~permit~~ by giving it a sudden but gentle twist you will be enabled to bring the forceps around the parietal protuberances. Do not force rotation but facilitate it. Compression only sufficient to enable you to make the proper degree of traction is all that is necessary. When you use leverage always make it from handle to handle. When is, after the head arrives at the inferior strait nothing peculiar to this case. - When the head is oblique & in the 2nd position the peculiarity is that the male blade is the pubic blade & will therefore have to be passed first. This makes it somewhat inconvenient. In the 4th & 5th positions the handles will have to be depressed to allow extension ^{when the head comes out of} the inferior strait. - When the head is not oblique, but the occiput is at the left groin, ~~which~~ is called left occipito position, I think the use of the forceps is improper, until with the lever passed behind the occiput you have thrown the head in an oblique position. Dr. Levee advised that the forceps be introduced first & when you have twisted the head in the proper oblique position, withdraw them & take hold of the head again



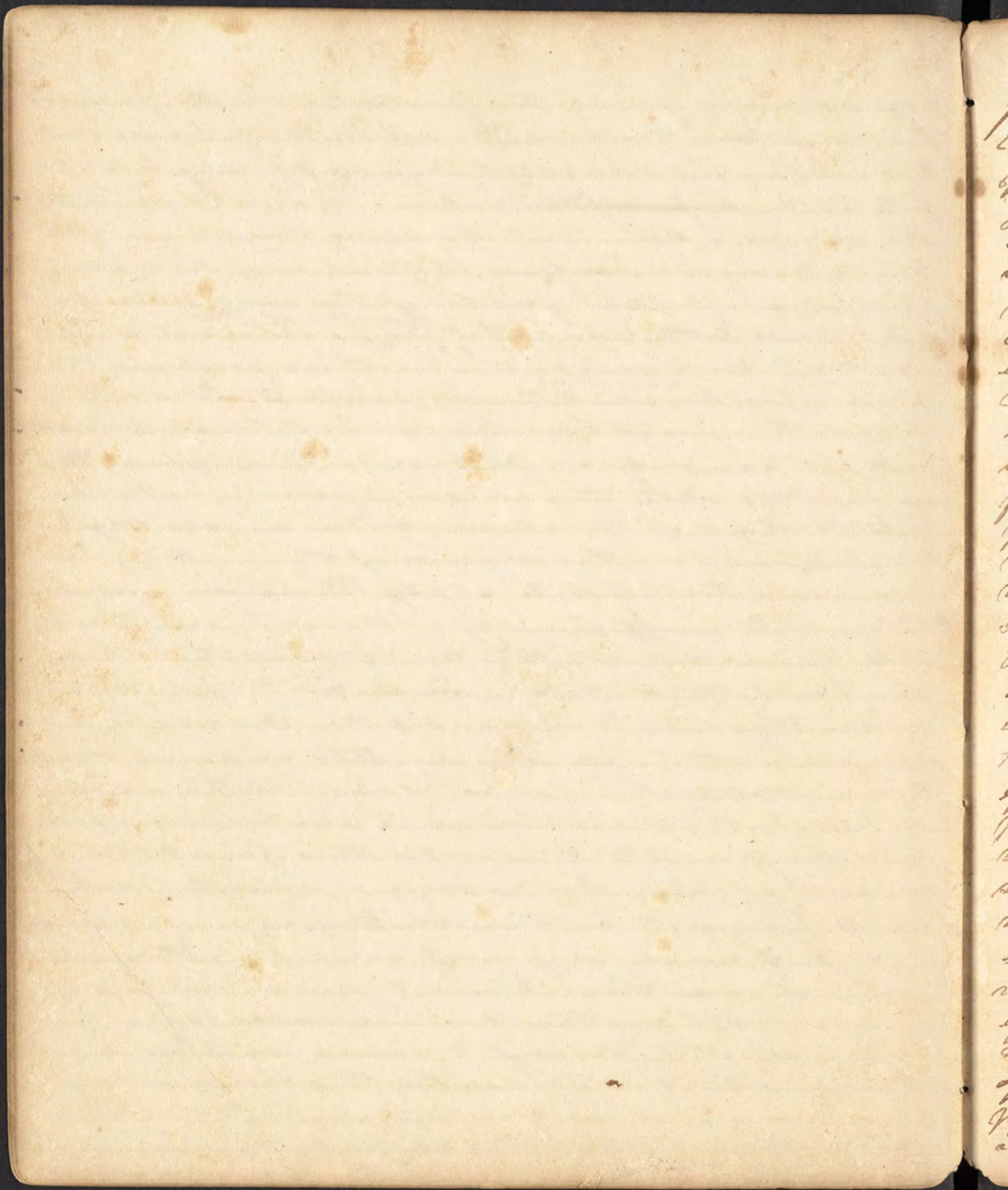
secundum artem, The Germans are not particular at what part they take hold of the head so that they draw it through the canal of the pelvis with the most favorable diameters engaged. — The application of the forceps at the superior strait is much opposed by the English. The French practice it, & I see no reason why it may not be pursued. If properly done this application of the forceps is much more safe than version by the feet. If a man have equal experience with the forceps here & version by the feet, the former should be chosen as being safer to the child & its mother. — When the head is at the superior strait & in the first position, the small blade is to be introduced first, when in the 2^d position the female blade will have to be introduced first. The third position may be changed to the 1st or 2^d by pushing the head up out of the superior strait & ~~then~~ twisting the forceps ^{to} the the left or to the right. The 6th position may be converted in a similar manner into the 4th or 5th position.

Lecture XL, February 10th 43.

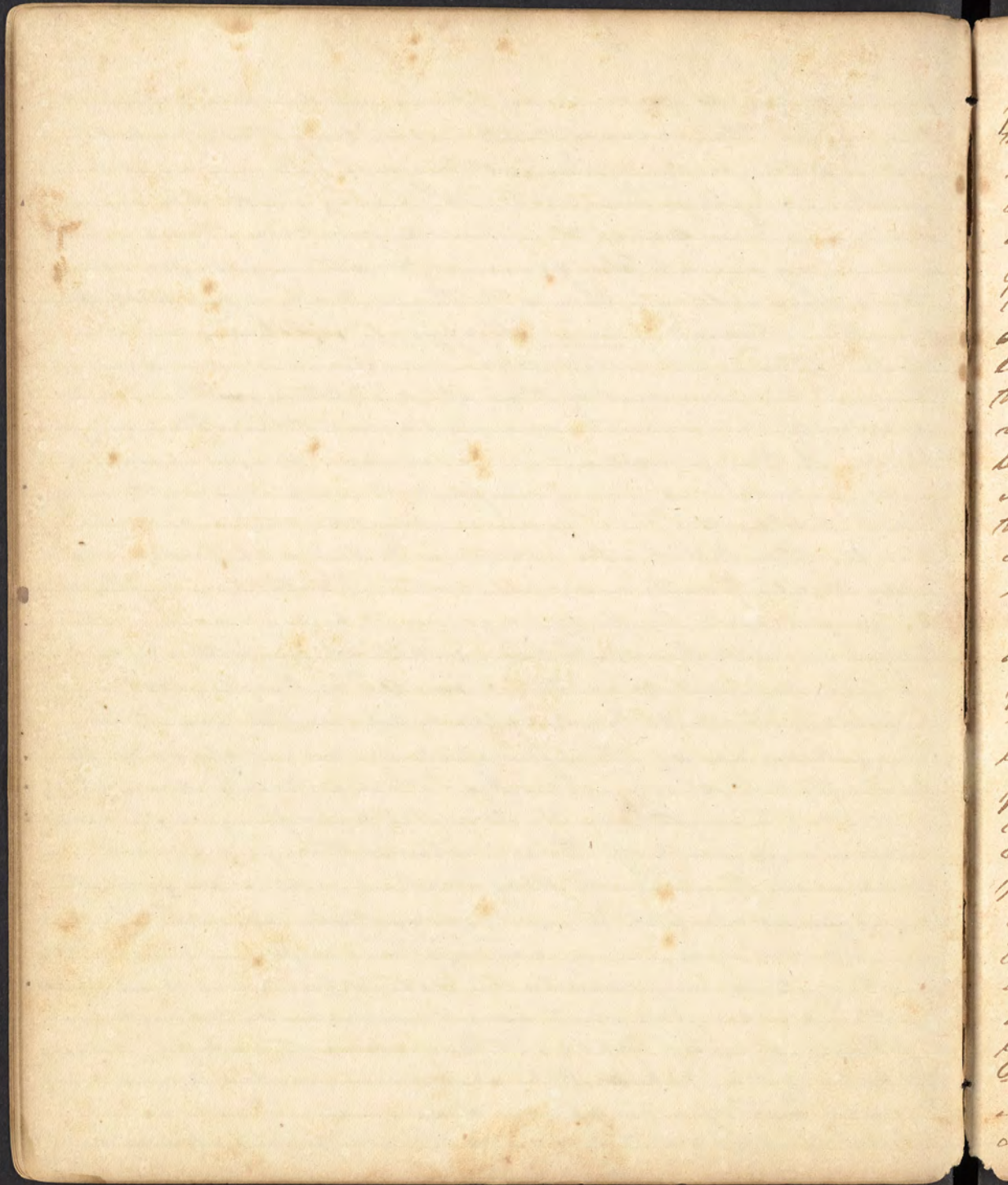
The head may be situated transversely at the superior strait & thus arrested. From the dangers which arise from applying one blade under the pubis & the other on the sacrum, (the bladder being much endangered,) it is better to use the lever to make the head oblique, & then apply the forceps. In some instances the vertex may be drawn down with it in such a position as that the delivery may be accomplished naturally. Or by drawing the vertex down you may facilitate rotation, & then when it gets into the cavity of the pelvis facilitate rotation



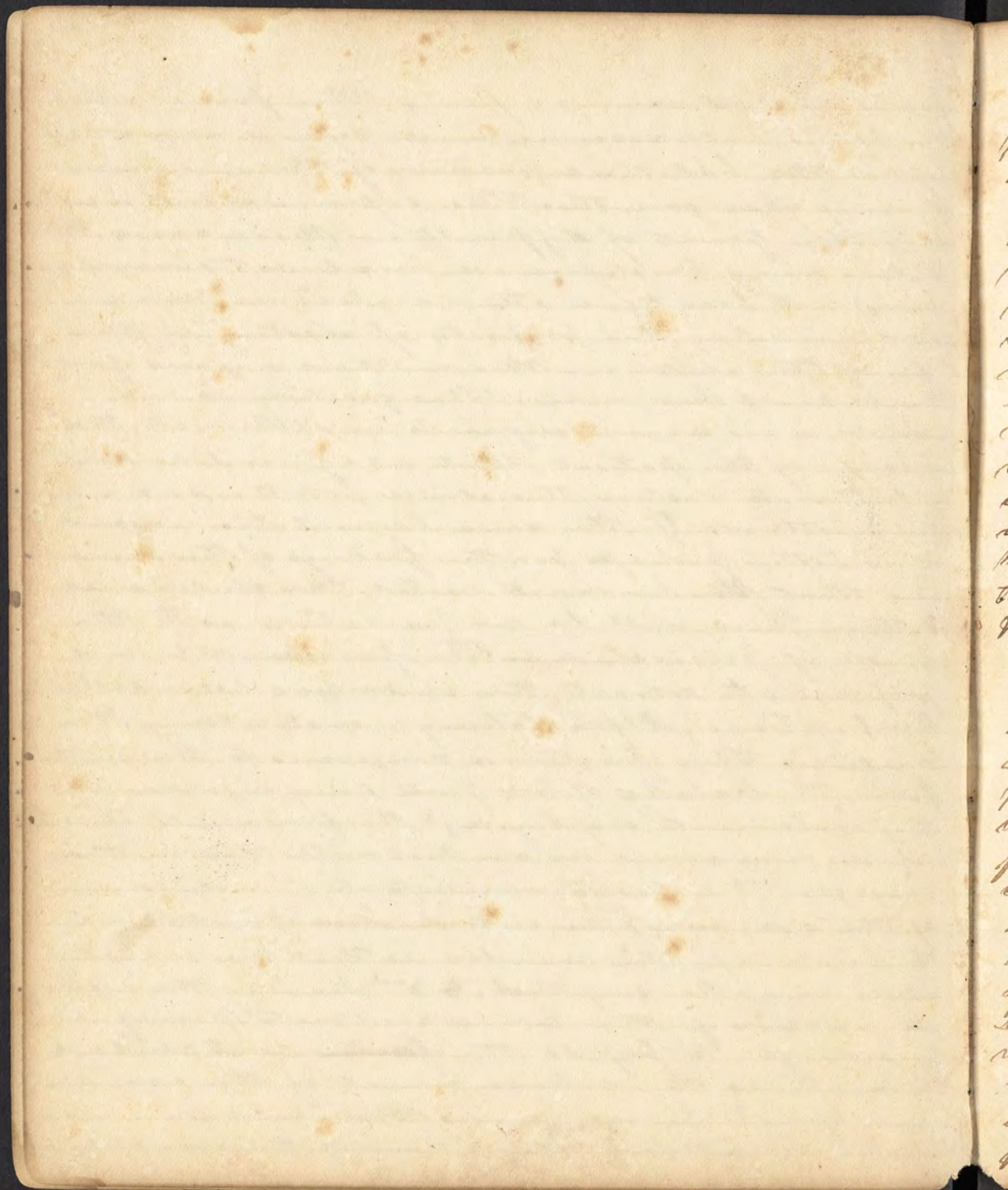
& if necessary finish the operation with the forceps.
 In the pelvic positions the whole body being de-
 livered the head may remain in spite of our ef-
 forts at the ~~exit of the~~ vulva. It is in this case that
 the forceps are particularly useful. They being ap-
 plied secundum artem, traction may be made,
 remembering that flexion of the head should
 take place & therefore that the forceps must rise
 as the head comes out. — In these positions the
 head may be ^{corrected} at the superior strait. It is difficult
 to get the forceps over the head of the child, with-
 out, it can only be partially accomplished. And
 if in this state the same position will be
 apt to wound the child, & the lower edges
 the uterus or other organs of the mother. Dr
 Denes attempted to apply them in one in-
 stance but ineffectually. I have tried it sev-
 eral times & with the same result. I there-
 fore think that it is impossible to use them
 advantageously here, unless they be very much
 curved, & then it is a matter of some doubt.
 In most cases the hand applied to the shin
 or occiput or one hand to each, will effect
 our purpose. But should this fail & the
 child be dead, by passing a blunt hook
 up & fixing it in the orbit you may always
 with not much difficulty accomplish the end
 in view. — Sometimes by unscientific &
 violent traction the head is ~~partly~~ separa-
 ted from the body, & remains fixed in
 the mother's organs. In this case you may
 pass the hand in & bring down the ves-
 tice or the shin. Should you require any



further and you may pass a blunt hook
 through the mouth & reaching the palatine
 process pull against them. These will
 generally give way; but ^{this} will not be an in-
 convenience since the hook will afterwards
 come against the firmer & stronger part of
 the maxillary bone & thus have a suffi-
 ciently strong "point d'appui". There are a vari-
 ety of instruments called extractors for this purpose.
 One of the simplest is the stick & string. The lever
 is usually made rather more curved than the single
 blade of the forceps. The lever has its appropriate of-
 fices as well as the forceps, & these are for the most
 part distinct. The former should not be substitu-
 ted for the latter. — The lever is to be used for cor-
 recting mal-positions, facilitating rotation & flexion.
 It ought not to be, as a general rule, used for trac-
 tion or as a lever. I advise all of you to study well
 its use, & practice with it in as a tractor & lever,
 in order that when called upon to use it in
 the absence of the forceps you may operate bene-
 ficially & not injuriously. When using it as a lever
 protect the mother's parts with your fingers; do not
 make any part of the mother the fulcrum. In
 some cases the more the instrument is curved the
 more powerful it is, with a certain limitation.
 = There are some cases ^{in which} from deformities of the
 mother it is impossible to deliver per vias naturales
 if the child be not compressed or so cut up
 so that it may pass. (There are two specimens
 of enlarged pelvis. Those women who have such
 pelvises ^{have} ~~are~~ of averse any deliveries. — There is a spe-
 cimen of contracted pelvis. This probably a case



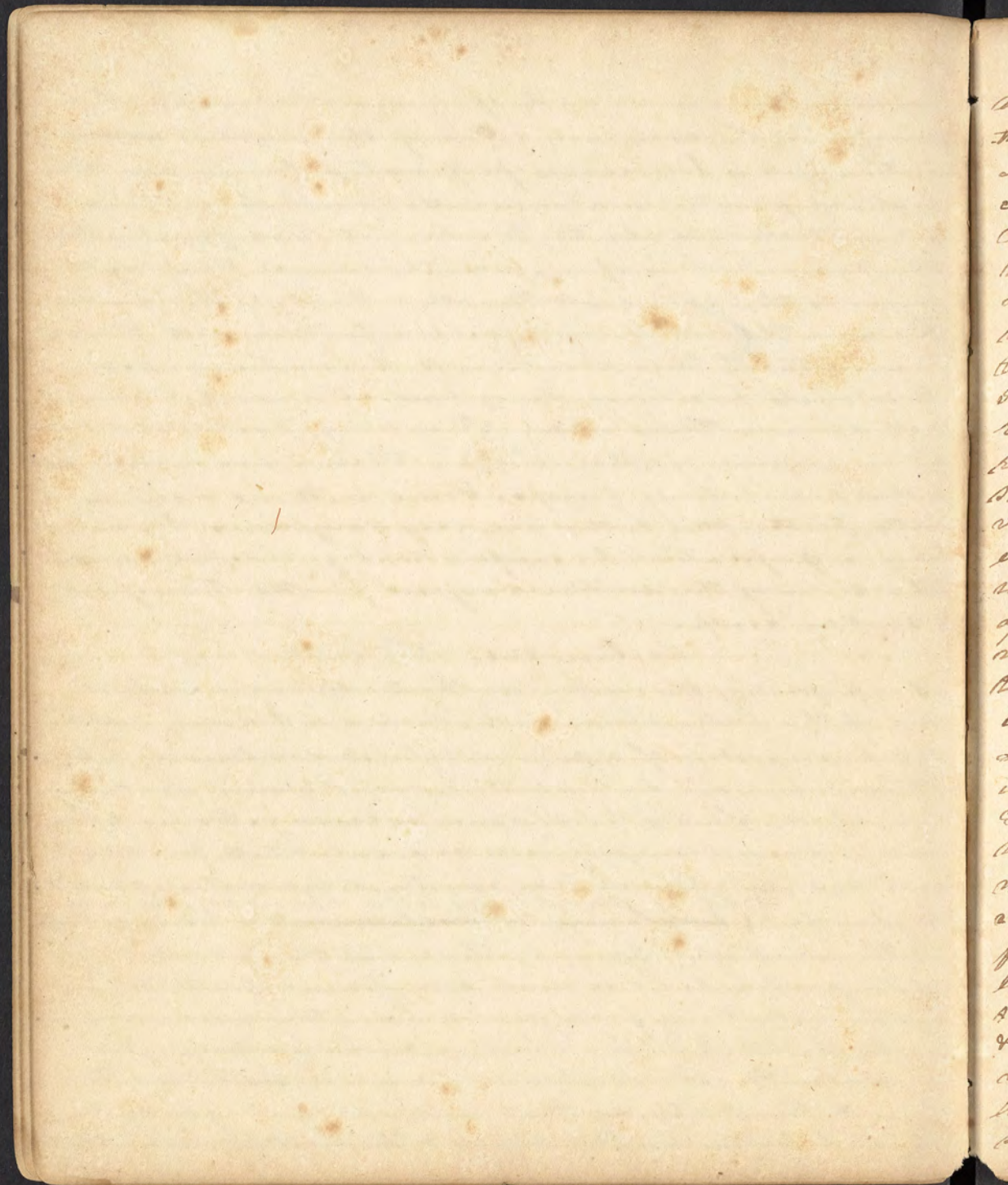
from pockets during infancy. The form which the pelvis will assume will depend very much upon the habitual posture of the individual during her growth. The superior strait is usually the point of difficulty in these cases. The pelvis may be deformed in almost every manner. — A beautiful ethical question here arises concerning the propriety of destroying the life of the child in the mother's organs for the sake of her own. This question is one which is in a great degree to be settled at the bedside of the patient. But as a general rule it is better to destroy the child for the sake of the mother. If the case be not too urgent it is better perhaps for the feelings of the accoucheur that ~~the~~ he wait until the child dies & then there will be no hesitation as to the mode of procedure. — The operation which is performed to extract the child has been called Embryotomy, Cephalotomy, craniotomy, & Embryulias. This operation is dangerous to the mother from the liability of her parts being injured by the instruments employed, & the fragments of bone which may come in contact with her in their passage. The operation consists of 1st a division of the cranium & the introduction ^{and} of instruments to break up the membranes that the preceptor alone may be emptied, & 3rd leaving the rest to nature if the uterus contracts powerfully enough to expell the ~~rest~~ rest child. Sometimes the whole venter of the cranium has to be removed. This would leave a diameter from the chin to the root of the nose of four



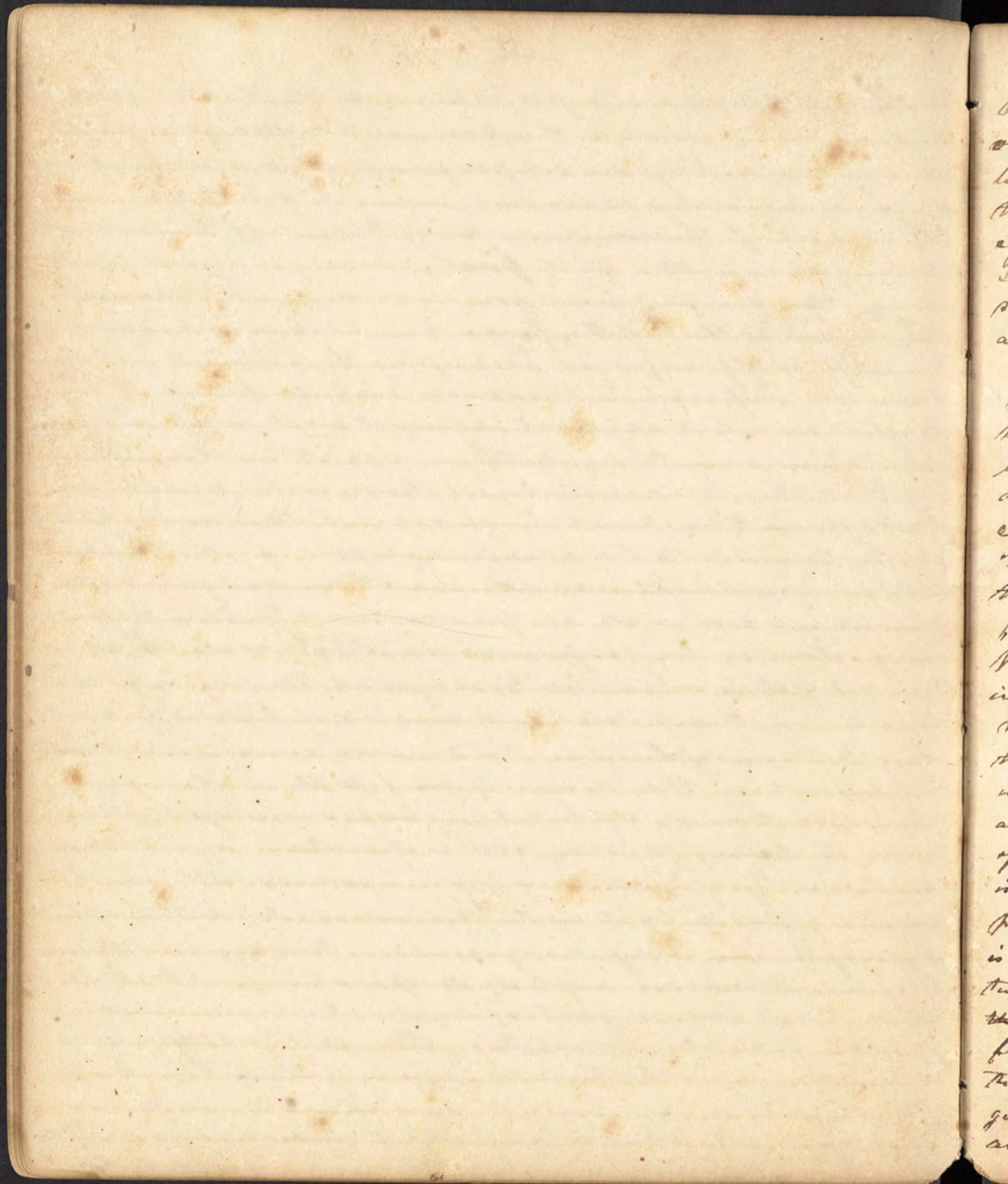
an inch to an inch & a half or an inch & a quarter. - For puncturing the cranium, One of the simplest of these instruments is Solerssens perforator. Remember it is a sharp pointed instrument. Smellie's scissors are introduced shut, & when it has penetrated the cranium is opened with one cutting edge towards the sacrum & the other towards the pubis. Be sure that it be not pushed farther into the cranium than the shoulders of the instrument. - Crotchets are very dangerous instruments, I would not advise their use. They may produce extensive injury if they slip. - There are instruments called craniotomy forceps. Some without & some with teeth the latter are very dangerous. In making a perforation be careful that you do not mistake some of the mother's organs for the thence & swollen scalp.

Lecture XLI. 17th 1843.

For perforating the cranium, the Trepan & saucula is one of the best instruments. There is a German instrument, consisting of a curved cylinder containing a Trophine which can be pushed up or withdrawn as it may be wished. This is hardly ever necessary. Davis's spring forceps have been proposed as a substitute for the crotchet. Mr Brown has constructed a crotchet which is guarded; ~~It is something like a forceps~~ ^{It is something like a forceps} there is a blade which is the agent of slipping will receive the sharp edge of the crotchet. It is not a sufficient protection. Davis's osteotomy forceps act something like a shoe-maker's punch. The blade which is exteriorly with regard to the skull should be used between the bone & the scalp, so that a kind of bag may be formed between the bone & the soft parts of the



mother, to afford some protection to the latter, one of
 the best & most convenient instruments is *Mead's* craniot-
 omy forceps. They are simple forceps with serrated fa-
 cings, more or less curved according to circumstances.
 The vault of the cranium being taken off remember
 to bring down the face first, for should you bring
 down the occiput first you will have the ^{of the neck} diam-
 eter added to that of the face. & and I have seen
 that a pair of forceps for compressing the cranium & these
 I am not disposed to condemn unequivocally. The
 English writers say that it would ruin any man's
 reputation even to apply them once. The French
 say that they have employed them with much ad-
 vantage. — The operation of cephalotomy may gen-
 erally be said to be a safe one, for if it were
 not performed ~~the~~ would die. The dangers of the
 operation are just in proportion to the defor-
 mity. It may be performed in those cases of con-
 tracted pelvis when the passage at the superior strait
 has an antero-posterior diameter of $1\frac{1}{2}$ inch ac-
 cording to Davis of London. Dr Deewee considers it in-
 useful when the diameter is less than 2 inches.
 The operation of cephalotomy is then useless will
 have to be relieved by some operation upon the
 mother. Symphysectomy promises very little. Little
 can be gained by it as its diameter. And the ef-
 fects of it are, very disagreeable. It should I think
 be considered an exploded operation. — The Cae-
 sarian section, or gastro-hysterotomy is a better
 & more feasible operation. The greatest dangers
 are from prostration & peritonitis. Dr Long-
 head out of 30, only three cases have proved
 successful. Wapleau says that only about 1 in 2



have been successful, In this country about 7 or 8 operations have been performed; they have been more successful than elsewhere. In all the cases about 1 in 2½ have probably proved successful. The English put off the operation too long. Dr. Gibson performed the operation twice on the same woman. The children I will show you at the next lecture.

Lecture. XLII. Feb. 21st.

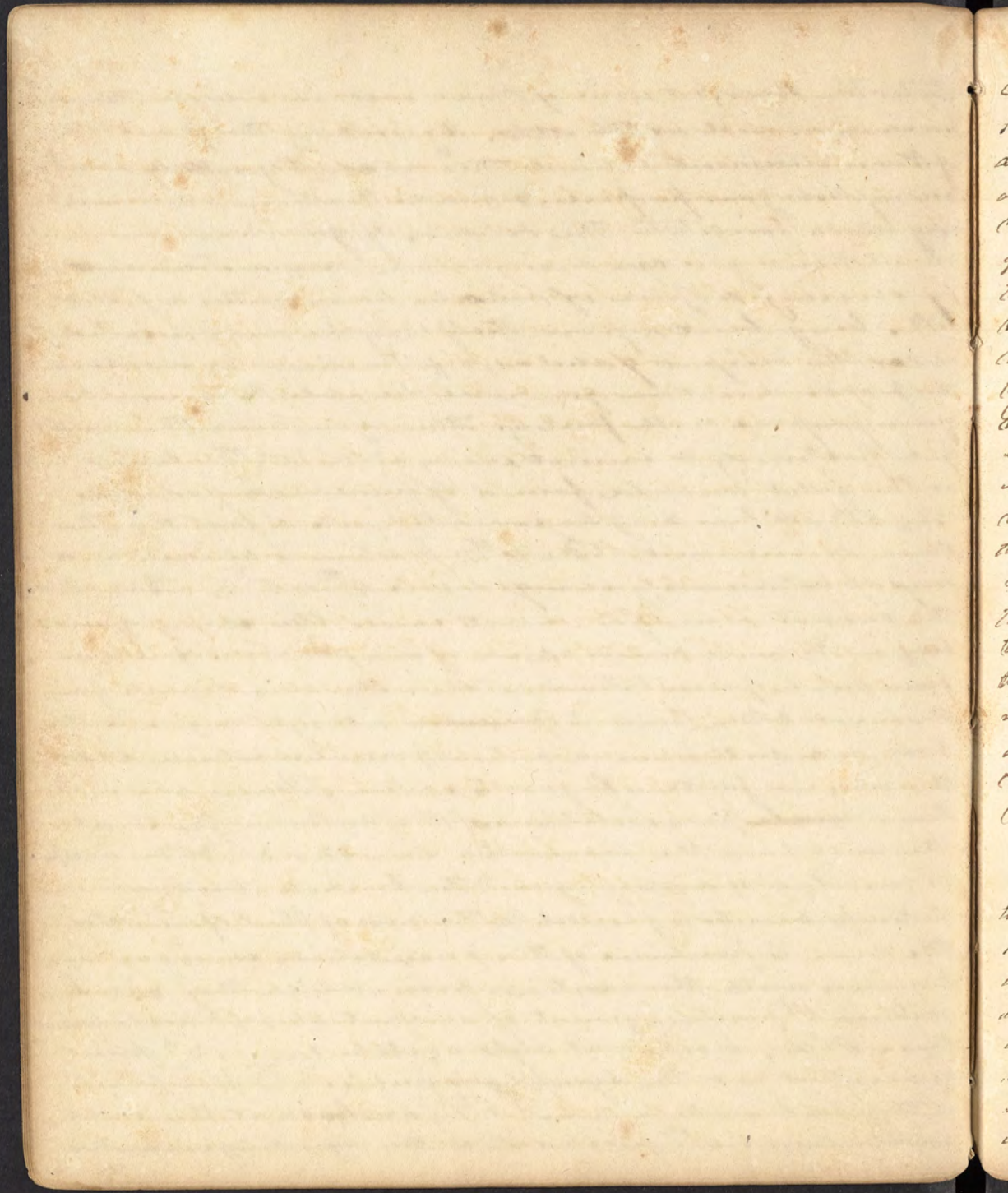
I have the pleasure of presenting to you the two children spoken of at the last lecture. This little girl is in her 9th year; the little boy is in his 6th year. "Seeing is believing"; gentlemen. When the antero-posterior diameter of the superior strait is from 2 to 3½ inches the operation for craniotomy will be proper. When the diameter is less than that 2 in. is generally agreed that the operation will be extremely hazardous. I am informed by a respectable student that a physician in this part of the country performed the caesarian section in a case after the child had been delivered per vias naturales. — I am thus come to my knowledge in which the caesarian section was performed twice on a woman unnecessarily, in the state of Ohio. The details of it are pretty tedious. The woman at last died of rupture of the womb in the place where it was cut. — There is an other operation, viz that of premature labour or the production of abortion by artificial means. This operation is performed for one woman in whom it has been ascertained from the experience of at least one labour that there is no possibility of delivering a child at full term. The best mode of procuring it is by rupturing the membranes. This exposes the child to danger from undue pressure. But this is not so great as the danger which the mother would be exposed to

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in the plan of inserting a sponge tent into the os uteri, or partially detaching the membranes from around the mouth of the os, or where ergot is used. - We say as a general rule the occipito bregmatic & biparietal diameters are each about $2\frac{1}{2}$ inches at the 7th month & 3 in at the 8th month. - The most approved perimeter is the finger, measuring from point of symphysis pubis to the superior spinous process of the sacrum & then deducting the thickness of these bones is uncertain, since as in this specimen, I now exhibit the pubic bones may be joined at an angle differing from the natural one, & the thickness be more or less altered as regards the sacrum. By measuring the distance from the interior of the arch of the pubis to the promontory of the sacrum & then deducting $\frac{1}{2}$ an inch we have a pretty sure means of ascertaining the antero-posterior diameter of the superior strait. This operation seems to be an established one. The English perform it frequently; it has thus far been favorable. Dr James was the first to perform it in this country. - Before we speak of complications of labour from Malposition I will call your attention to some points in positions of the vertex at the Superior Strait. When the head is in the 3rd position much good may be done by changing it to a 1st or 2nd. Either the right or left hand may be used for accomplishing this. But as the right hand is the most convenient with most persons, by placing of the fingers on the left of the mother you can push the occiput into the 2nd position, (By placing the fingers on the right you can convert it into 1st). When the head in the 4th position gets into the cavity of the pelvis you may convert it into the 2nd. If not called in time to do this with the hand, this is a case for the forceps. If the forceps be at hand you may substi-

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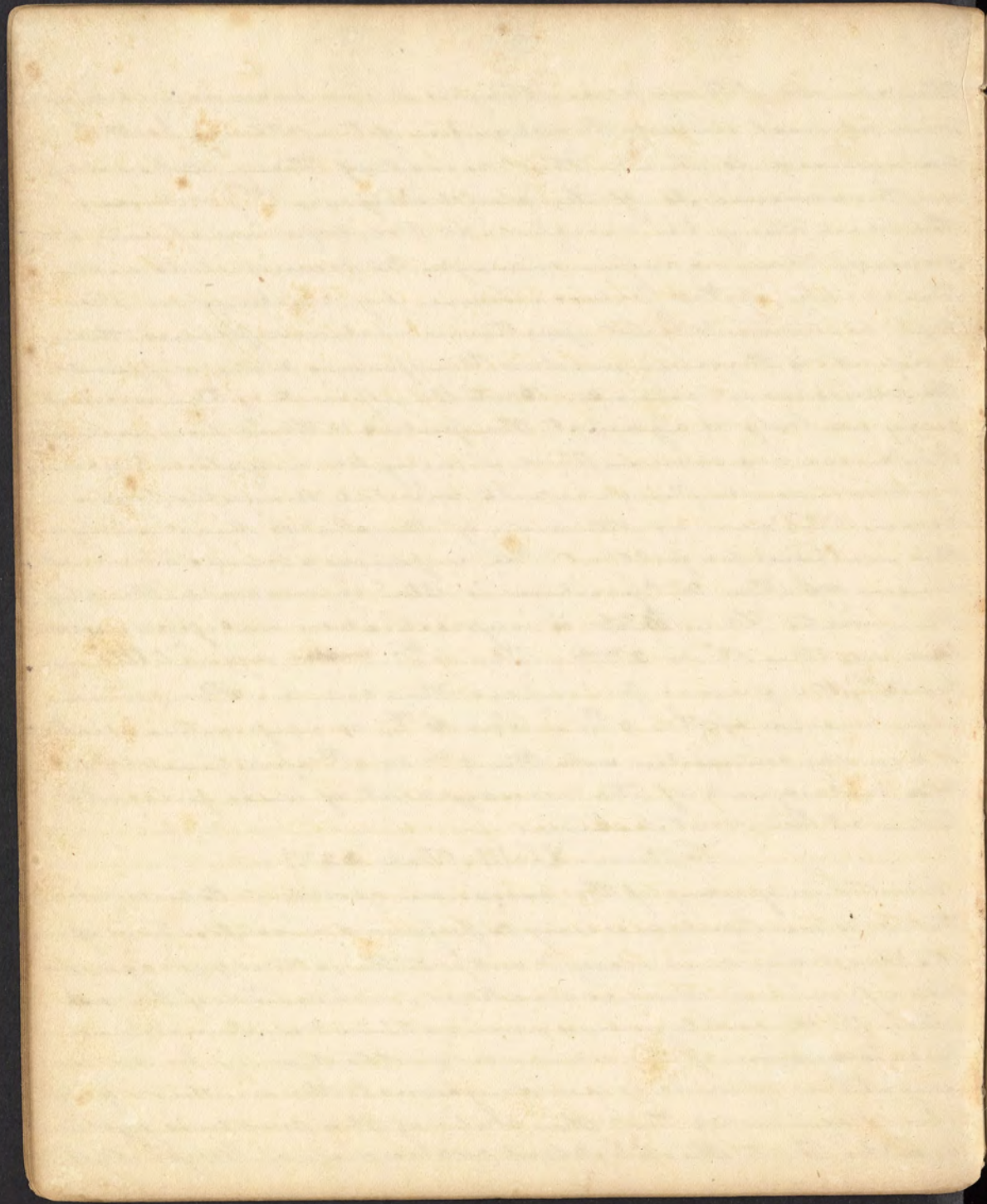
turns the lever, & it is one of those cases in which the one
 answers as well as the other. By hooking the fenestra
 of the instrument behind the occiput you may easily
 accomplish your purpose, & make traction which will
 very much facilitate the labour. If you have no le-
 ver at hand you can easily make one instrument
 by covering a piece of cuticle bone with a fillet,
 this being bent upon itself may be easily inserted
 under the occiput of child, & if traction be made in
 the proper direction you will be able to accomplish
 your purpose with facility. When you have the occi-
 put posteriorly, & cannot easily alter it, the lever
 or this fillet will be found of immense importance.
 The 5th position may be converted into a first by the
 same manœuvres. The 6th position is almost al-
 ways spontaneously changed into 4th or 5th. But when
 this does not occur you must cause the change your-
 self. We will now speak of complications of labour
 from mal-presentations. — When the chin departs from
 the breast & the head is presented at right angles to the
 body, we shall have a position presented which is as
 the anterior fontanelle for its centre. Hence we call
 them ~~mal~~ presentations of the anterior fontanelle.
 We will have the biparietal diameter 5 $\frac{1}{2}$ & the occip-
 ito mental 4 in engaged, & the trachelo-brachiatric or
 vertical diameter is parallel to the axis of the superior strait.
 We have 6 positions of this presentations corresponding
 precisely with the positions from which they are de-
 parted. 1st position point of occiput at left acetabulum.
 2nd the occiput at right acetabulum. 3^d point
 of occiput at the symphysis pubis. 4th forehead
 at the left acetabulum, 5th forehead at the right
 acetabulum. 6th forehead at the symphysis pubis.



The causes of these presentations have been ascribed by some almost entirely to obliquities of the uterus, but I am inclined to think that most of them depend upon the movements of the child itself. - 1st position. The head may be arrested at the superior strait, but generally there is room enough to permit it to enter the cavity of the pelvis. When by striking on the left anterior & right posterior inclined planes the occiput is thrown under the pubis & the difficulty vanishes at once. But the point of the occiput may be lodged against the pubis & thus be arrested. Dr Barnes has shown that it may be arrested by coming down with the occipito mental diameter (transverse). The ear or the side of the child's head may in this instance be felt at the inferior strait. The mechanism of the 2nd position is the same with that of the first. The 3rd is impracticable unless converted into the 1st or 2nd. The 4th ~~position~~ differs a little from the 1st; the general principles the same. The same may be said of the 5th. The 6th is impracticable. It is usually converted into the 4th or 5th spontaneously. We will speak of the management of these presentations at the next lecture.

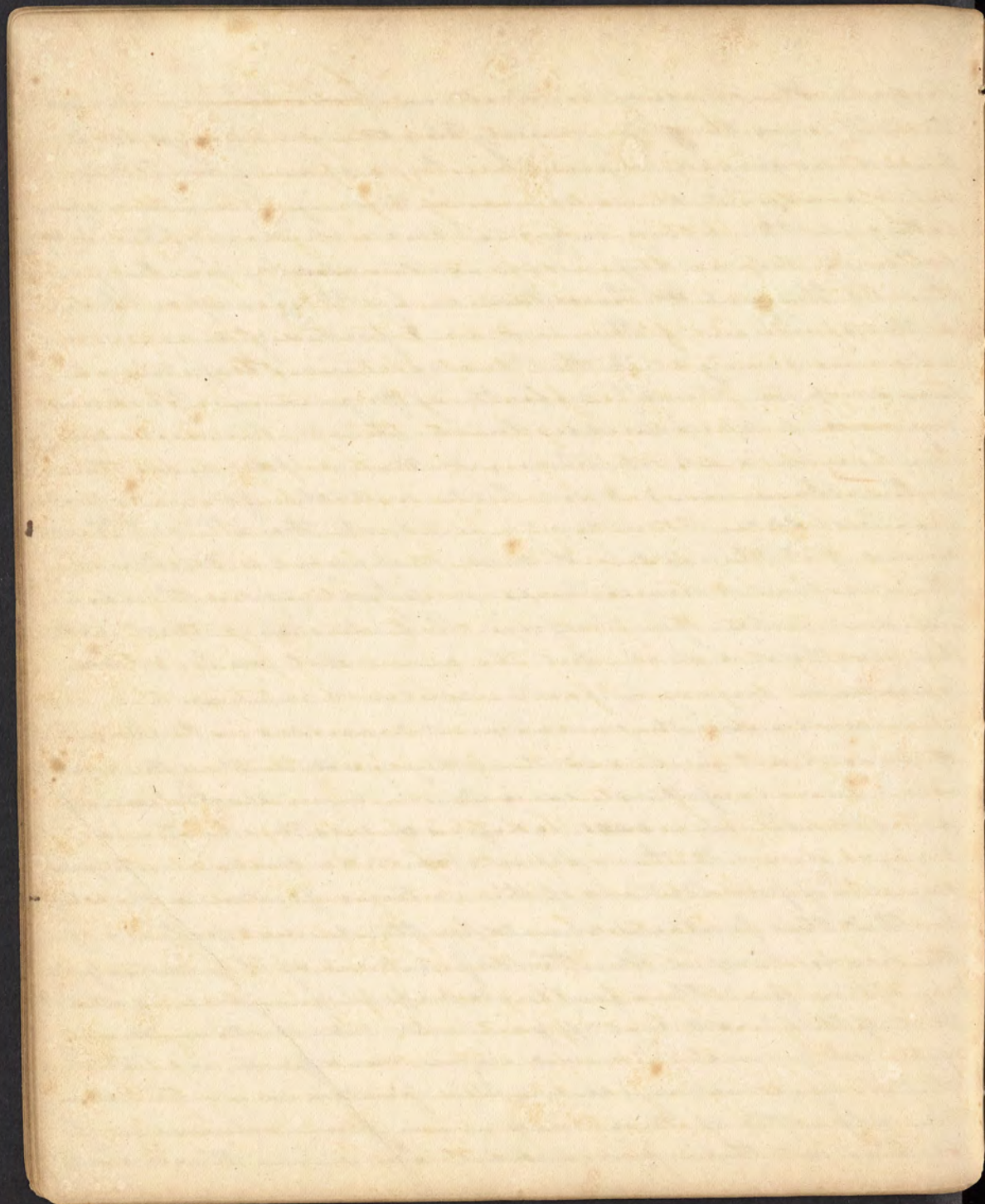
Lecture XLIII. Feb. 22nd

I omitted in speaking of the caesarian operation to mention that it is sometimes necessary to perform a modification of it. Thus it may be necessary to cut into the uterus *per vaginam* when from any cause, as cicatrices, obliteration of the uterine orifice, fibro-cartilaginous indurations &c. Sometimes in retroversion of the uterus a resort to it may be necessary. These operations are dangerous to the mother. You should remember that the state of the mother's system is such that the slightest wounding of her parts,

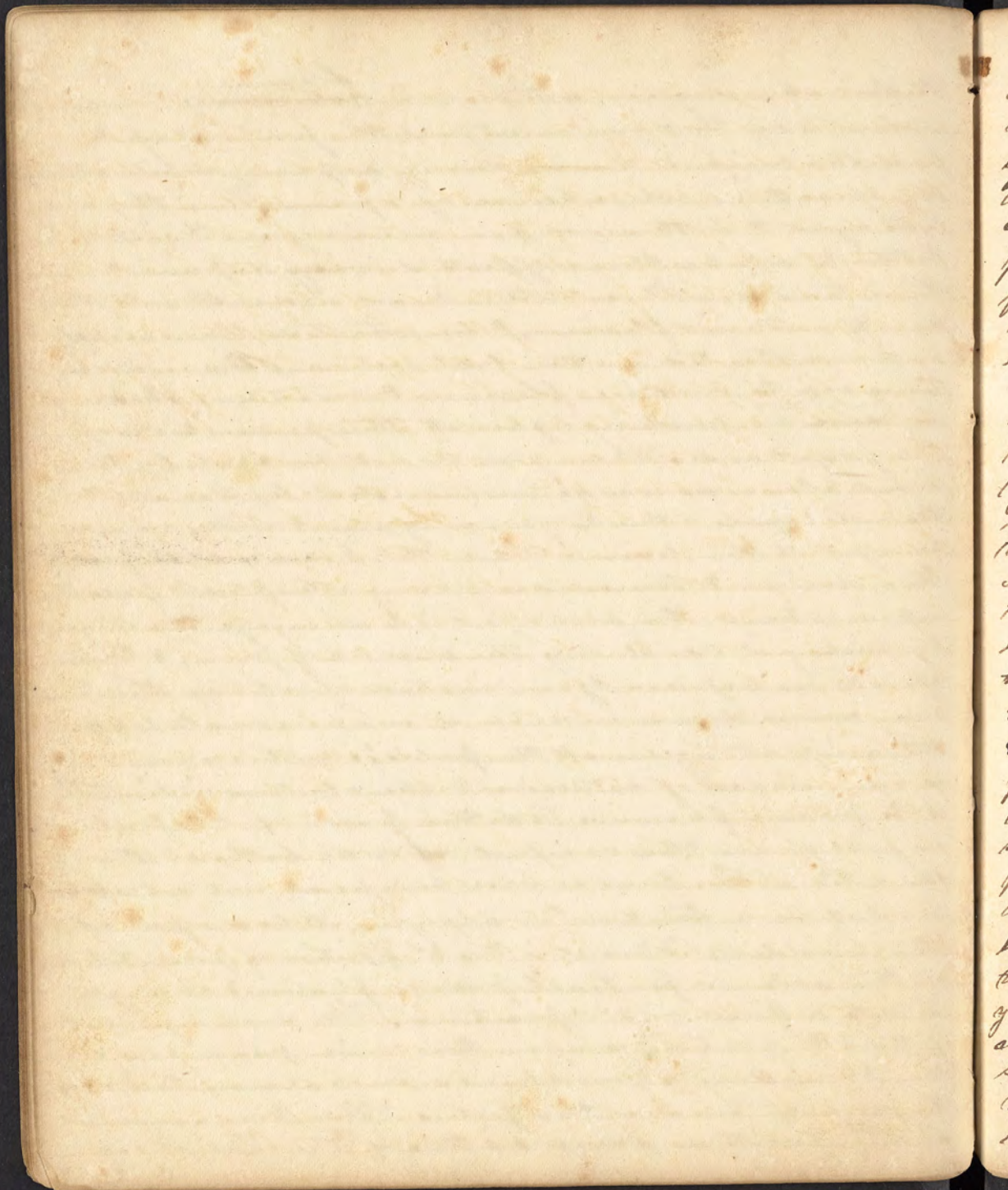


may be the cause of her death. — When Women die in the 7th month of pregnancy they should always be delivered as quickly as possible. Care should be taken not to commit more violence than if you were operating on the living subject. The child may often be very easily delivered per vias naturales by making room by the feet & ~~then~~ ~~turn~~ or by the forceps. Here is the specimen of the womb & foetus of a woman who was brought to the Pennsylvania Hospital as was said in the 9th month of pregnancy. She had received a very severe burn which terminated her life in a short time. Dr Randolph made the section (Caesarian), & we took out the foetus which you here see. It evidently is a bout the 6th or 7th month of utero-gestation. It had died probably at the time the mother received the severe shock from the burn. Be sure when you perform this operation that ~~it is~~ the mother is dead, yet do not wait ~~as long as~~ ~~to make it~~ enough for the child to die. —

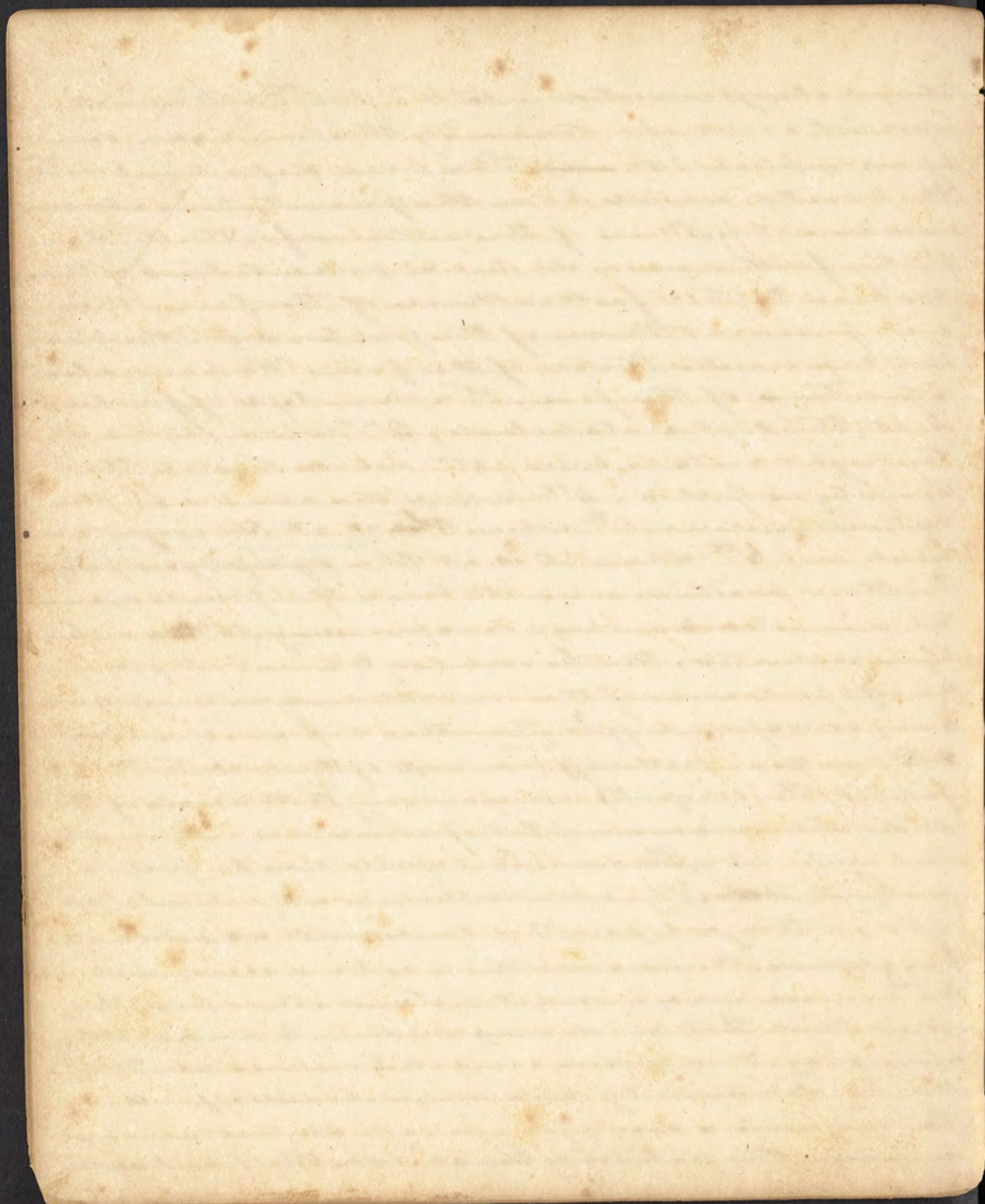
I am well aware that many practitioners are in the habit of being at first just as soon as they ascertain that the cephalic extremity of the child is presenting. But I think you should never ~~not~~ ~~satisfied~~ unless the vertex is brought down to the inferior strait. In making out your diagnosis of presentations of the anterior fontanelle remember that this fontanelle should be the lowest portion of the head. Now in the third position of the vertex you may often feel this fontanelle before you do any other part of the head but if you will take notice there will be found a more dependent part, in the center of which will be the posterior fontanelle. The difficulties of these cases arise from extension of the head at the superior strait. Hence in these cases



the obvious indication is to produce ^{flexion} ~~extension~~. Some authorities say that you must push the forehead up & pull the occiput down during a pain, while others say operate in the absence of a pain. Now they are both right & both wrong in some degree. For it is better to awake these efforts during a pain & in the intervals. — Should the head descend into the cavity without flexion, & be situated transversely as demonstrated in the last lecture, the indications are to produce flexion & rotation. This may be ^{fulfilled} ~~done~~ by pushing against the pubic side of the forehead. When you do not succeed by the hand alone as was recommended by Dancers & Baudeloque, I think you may resort with much benefit to the lever. — When the head is still further down & transverse, having attempted to pass the inferior strait, the first object is to disengage the head by pushing it up during the absence of pains, & then operate as before. — Again instead of rotating the head may come down in such a manner as to lodge the occiput against the pubis; in this case there is an increase of extension & the obvious indication is to produce flexion. To do this push up the forehead or pull down the occiput ~~or~~ or do both at the same time. The lever is here beneficial not as a lever but as a tractor. In applying it be careful of the bladder. When it is the 3^d position of presentation of the anterior fonticell produce flexion & change it into a first or 2^d position. The management of the 4th position is upon the same principles as the preceding. You should endeavour to bring the occiput under the pubis. The management of 5th position same as the 4th, the 6th is



almost always converted into 4th or 5th. When it does not occur spontaneously the head can easily accomplish it. — The head departing from the breast we will have the presentations already considered, viz, those of the anterior fontanel; departing farther we will have presentations of the forehead & still farther those of the face. We will pass over those of the forehead for the present & consider those of the face. We have also 6 positions of the face, 1st when top of forehead is at the left acetabulum, 2nd when it is at the right acetabulum, 3rd when it is at the Symphysis pubis, 4th when the chin is at the left acetabulum, 5th when ~~the~~ ^{chin} is at the right acetabulum, 6th when it is at the ~~Symphysis pubis~~ ^{symphysis of pubis}. In these positions we will have the fronto-occipital diameter 3 inches corresponding to the oblique diameter, the bi-malar $2\frac{1}{2}$ in (but from the soft parts covering the bones it may be considered 3 in) corresponding to the other oblique diameter, & the antero-posterior ^{4 in} from root of the nose to the point of the occiput) corresponding to the axis of the strait. The mechanism of these positions were not understood until lately. M^{re} Leconte Lachapelle was the first to point out ~~them~~ ^{it}. She considers them as all natural labours, although before they considered as extremely hazardous. We consider them as being cases in which the woman may in most instances deliver herself, yet we think that much may be done to make them more easy, & in some cases it is impossible that she be delivered by her own unaided efforts. The diagnosis is easy, for you can almost always recognize the features of the child. The head can

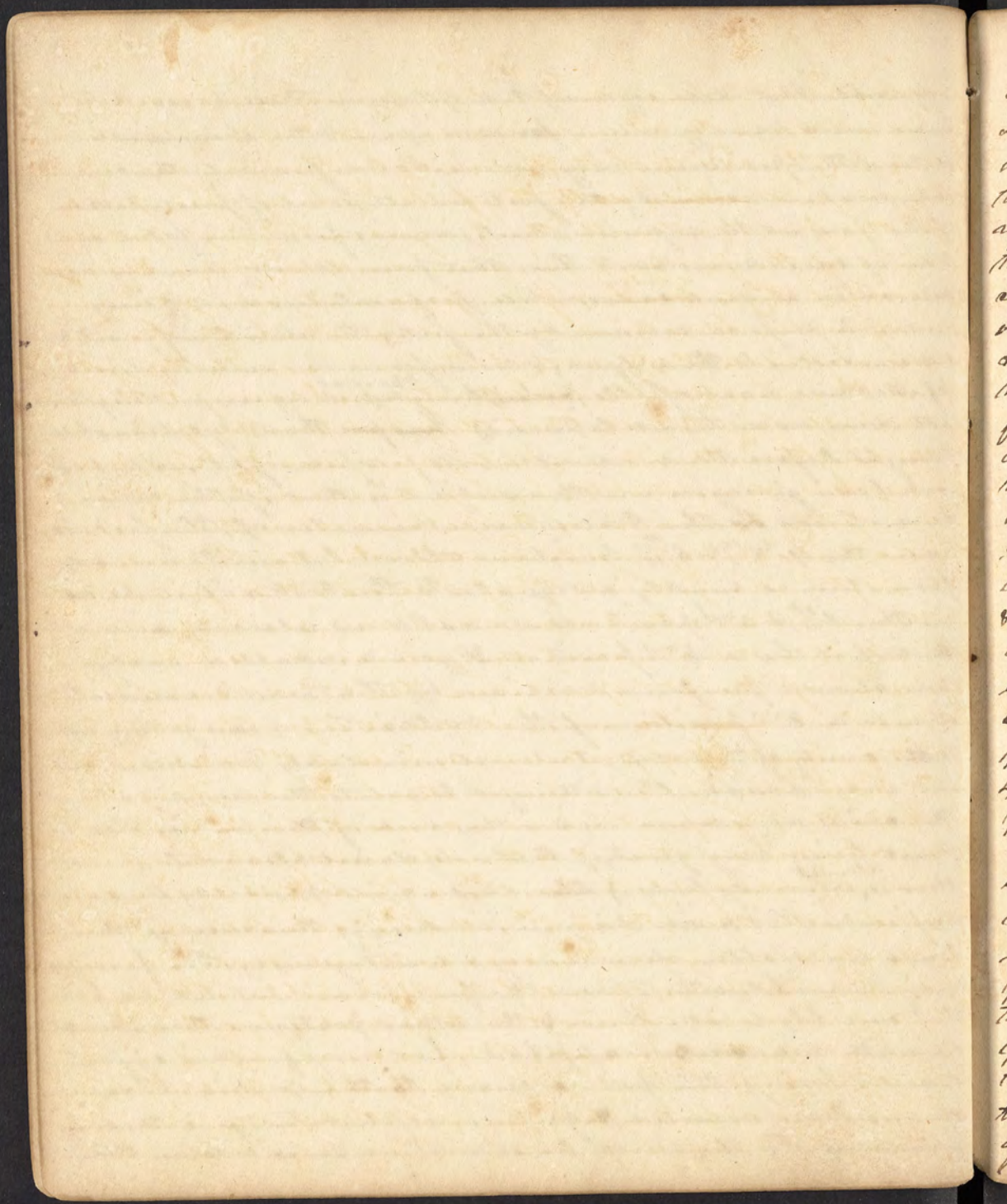


always pass it the proper diameter & brought in correspondence. In the 1st position the head may be made to pass the inferior strait if it be not transversed: the chin should be brought under the arch of the pubis. The 2nd position is nearly the same. The 4th & 5th positions are very much alike, & are more favorable than the 1st or 2nd because the chin very readily comes under the arch of the pubis. The 6th is nearly always converted into 4th or 5th. These face presentations are not so favorable as those of the vertex. As to the treatment some say you must interfere always & convert it into a vertex presentation. But my advice is to convert the anterior positions into those of the vertex by the operation of version by the head, if you are called early, but if the chin be anterior, or the head has descended into the cavity of the pelvis, endeavour to ~~change~~ bring the chin under the arch of the pubis & leave the rest to nature. When the chin comes under the arch & there is need of assistance facilitate flexion with the fingers, with the forceps, or fillet spoken of at the last lecture. To pass the fillet under the occiput you will of ten find Bolognini's instrument of much service.

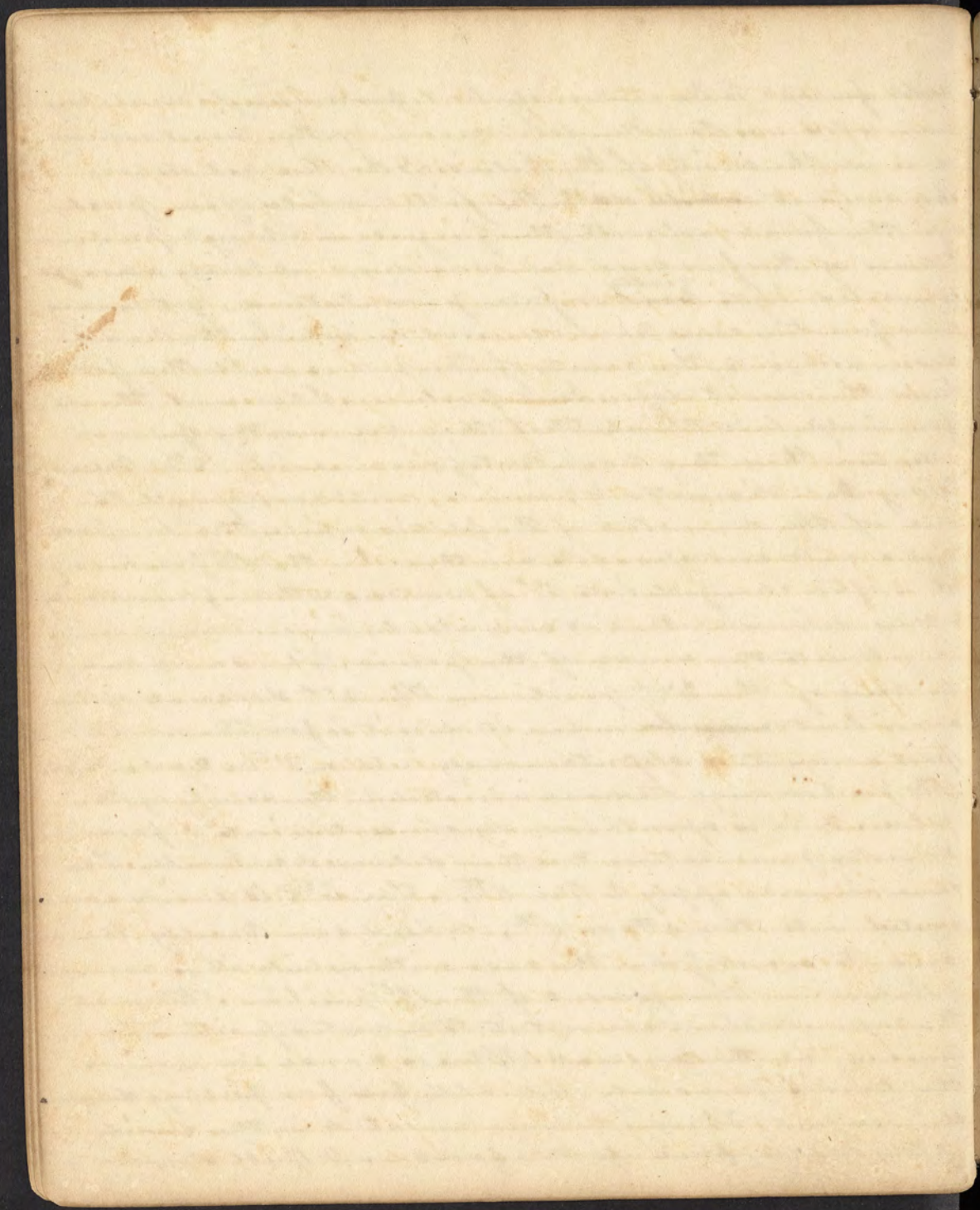
Lecture XLIV February 24th 1843.

In the 3rd position of the face, the head descending into the cavity of the pelvis the ^{occiput} head being against the pubis, & the chin in the hollow of the sacrum. (This is what is called the sacro-mental position). The contractions of the womb continuing, the body & shoulders are pushed down against the head, & the efforts to continue extension are counteracted. There may be a case of impracticable labor. The same would occur if the chin were not rotated under the arch of the pubis in the 1st & 2nd positions. In a very large pelvis it

is possible that delivery may take place in these cases. The head will be very much depressed upon & the chin will distend the perineum very much. It was formerly the custom make version by the feet in all cases of presentation of the face at the superior strait, arising from the fatal issue of cases similar to this. But from delivery having occurred in several cases, while preparations were being made to perform version by the feet, the attention of practitioners was called to the subject, & now from the investigations of Madame Lachapelle, ~~but~~ ^{she was} ~~though~~ turning in putting them all down as natural labours, ~~therefore~~ the subject has been brought before the medical in its proper light. - The best rule I can give you on this subject is that if the chin be anterior to the transverse diameter of the pelvis, as in the 4th, 5th, & 6th positions allow labour to occur, formation is amply adequate to the task. If it be as in the 1st & 2nd positions do as I have already advised. But if it be a 3rd position & you are called early you should perform version by the head & convert it into a 3rd position of the vertex. The head getting into the cavity of the pelvis, it almost inevitably perishes. But we should make the attempt to rotate the head so that the chin may come under the arch of the pelvis. The twist being very great, if the body do not also rotate, (and this is ^{almost} our only hope,) the child will probably be sacrificed. Not succeeding in producing this change the lever will often operate very advantageously. The forceps may be resorted to. When the forceps are rotated so far that one blade is anterior & the other posterior they should be with drawn & re-applied, for any farther effort would bring the pelvis curve to the pubis. These means being resorted to failing, cephalotomy is the only resource. If the child be still alive some advise the



apply forceps to be cautiously but perseveringly used. My
 own advice is to attempt version by the head while
 it is in the cavity of the pelvis. To do this set upon
 the occiput ~~with~~ ^{with} the fillet while you push
 up the forehead with the fingers. — Although presen-
 tations of the forehead are considered as being always
 converted into ^{vertex} head or face presentations, yet in my
 own practice cases have occurred in which the head
 descended into the cavity of the pelvis with the fore-
 head the most dependent portion. I cannot there-
 fore help but think that they are worthy of more
 attention than they have hitherto received. The men-
 te sagittal diameter $4\frac{1}{2}$ inches, will correspond to
 one of the diameters of the pelvis while the bi-par-
 ietas will correspond to another. In the 1st position
 it is often changed into 1st of vertex at the inferior strait,
 & thus delivered. But it may also be arrested when
 it gets into the canal of the pelvis. The same may
 be said of the 2nd position. — The 3rd does not often
 occur but ~~may~~ when it does it is for the most
 part converted spontaneously into a 1st or 2nd. — The
 4th position may become arrested in the cavity of the
 pelvis. Or it is spontaneously converted into a face
 or vertex presentation & is then delivered naturally. The
 same remarks apply to the 5th. The 6th is easily con-
 verted into the 4th or 5th, indeed can hardly be
 said to occur from the ease with which it is accom-
 plished. — Management of the 1st position. When at
 the superior strait convert it to a vertex position by
 pushing up the forehead. This is a case in which
 the lever is peculiarly valuable for pulling down
 the occiput. Having become arrested in the cavity
 of the pelvis, push up the forehead, & pull down



the occiput with the fingers & lever & these cause rotation of the occiput under the arch of the pelvis. The same directions apply to the 2nd & with slight modification to the 3rd. In the other three or occipito-posterior positions if you cannot immediately convert them into vertex presentations, bring down the face. The presentations of the chin or of the cheek may practically be considered as those of the face. - When the side of the head presents you will be able to recognize it by the ear. They are ~~almost~~ always very easily converted into vertex presentations. The lever will be a very useful instrument here also. - There are various deviated presentations of the pelvic extremity of the ellipse, but it would be rather a waste of time to go over them after what has already been said. Of some which exhibit peculiarities I will speak at the next lecture.

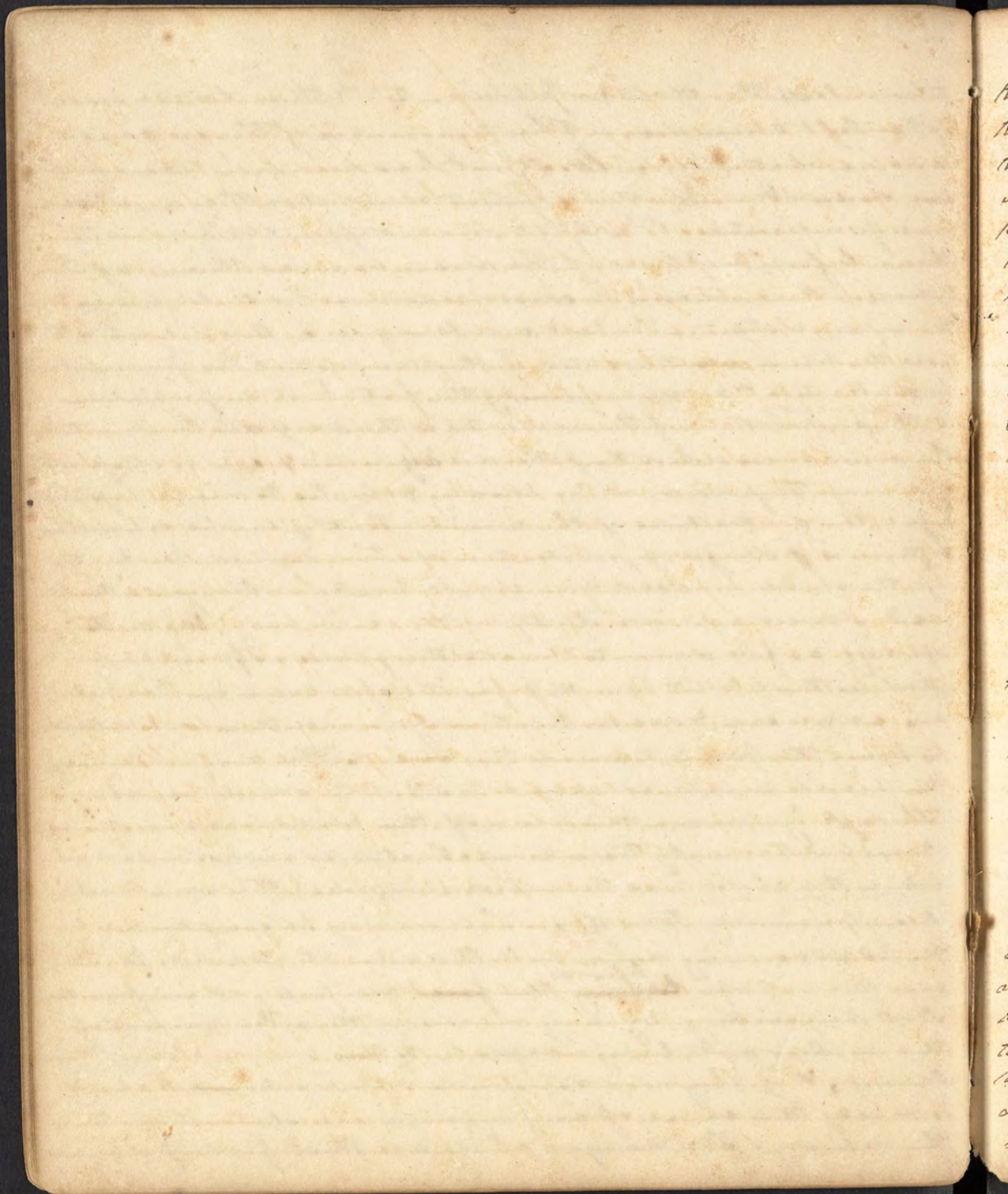
Lecture XLV. Feb 27th 43.

Presentations of any portion of the trunk of the child may take place. They were formerly very closely studied. Many of them are capable of undergoing spontaneous version. The attention of the profession was first called to this by Denham. Though very few of them are persistent, it will not do in all cases to temporise too long. - Presentations of the middle of the back are for the most part converted into those of the pelvis. When spontaneous version cannot be accomplished, or the ^{thing} is complicated by the assistance of the accoucheur, puncture of the child's body must be resorted to. - Presentations of the arm require more particular attention. We may have two positions of the shoulder or arm of each side at the superior strait. viz. 1st of the right shoulder (the dorso-pubic, in which the back of the arm is towards the pelvis, & 2nd the dorso-sacral. - 1st of the left

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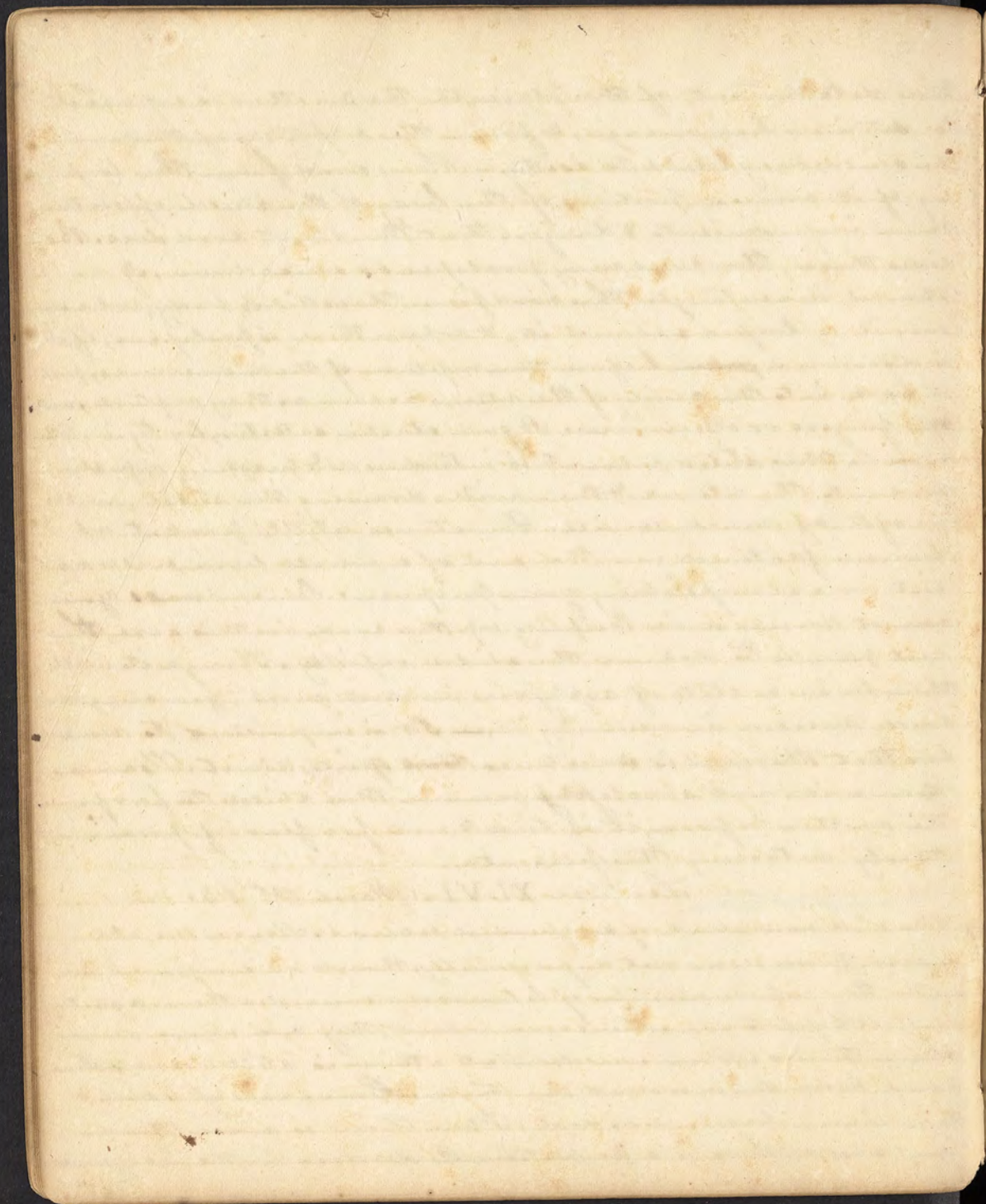
shoulder) the dorso-pubic - 2nd the dorso-sacral
 of the left shoulder. - The diagnosis of these cases
 is somewhat difficult. A foot has been mistaken for
 an hand &c. But you must remember the anatom-
 ical peculiarities. It is still more difficult to ascertain
 them before rupture of the membranes & than after-
 wards. - The mechanism ceases as soon as the child comes to
 the superior strait. - The best rule I can give in this subject is to
 pass the hand into the os uteri if the womb is not too powerfully
 contracted & make versions by the feet. I must ^{in proportion} ^{degree of} ~~in proportion~~
 to the contractions of the womb so is the danger to the mother.
 In some cases where the patient is vigorous & is in good spirits,
 you may temporize, using bleeding & opiates to make less pow-
 erful the contractions of the womb. But if she be exhausted
 & there is a danger of prostration no time should be lost.
 If the child be dead you should make no terms with it,"
 as Dr. Denes expresses it. Open the child's body; make the
 opening as far down to-wards the pelvis as possible, in-
 troduce the blunt hook, & fix it as far down in the pel-
 vis as you can, & make traction. You will thus be enabled
 to bring the pelvis to wards the strait. The amputation of
 the head is sometimes resorted to. But it is rarely necessary.
 Through ignorance the arm of the child has sometimes
 been barbarously torn away. Instances are recorded in
 which the child was delivered alive, when the arm had
 been previously torn off. - Labour may be complicated by
 the head's coming down with the arm at its side. In this
 case push it up ^{upward} ~~upward~~ the ~~front~~ occiput, or in front.
 Not succeeding by any means in this, the powers of
 the mother not being adequate to this accomplish the
 labour, & if they need assistance are ergot. - A short,
 is rarely the cause of any mechanical obstruction to
 the delivery. The dangers of it are, that from prema-



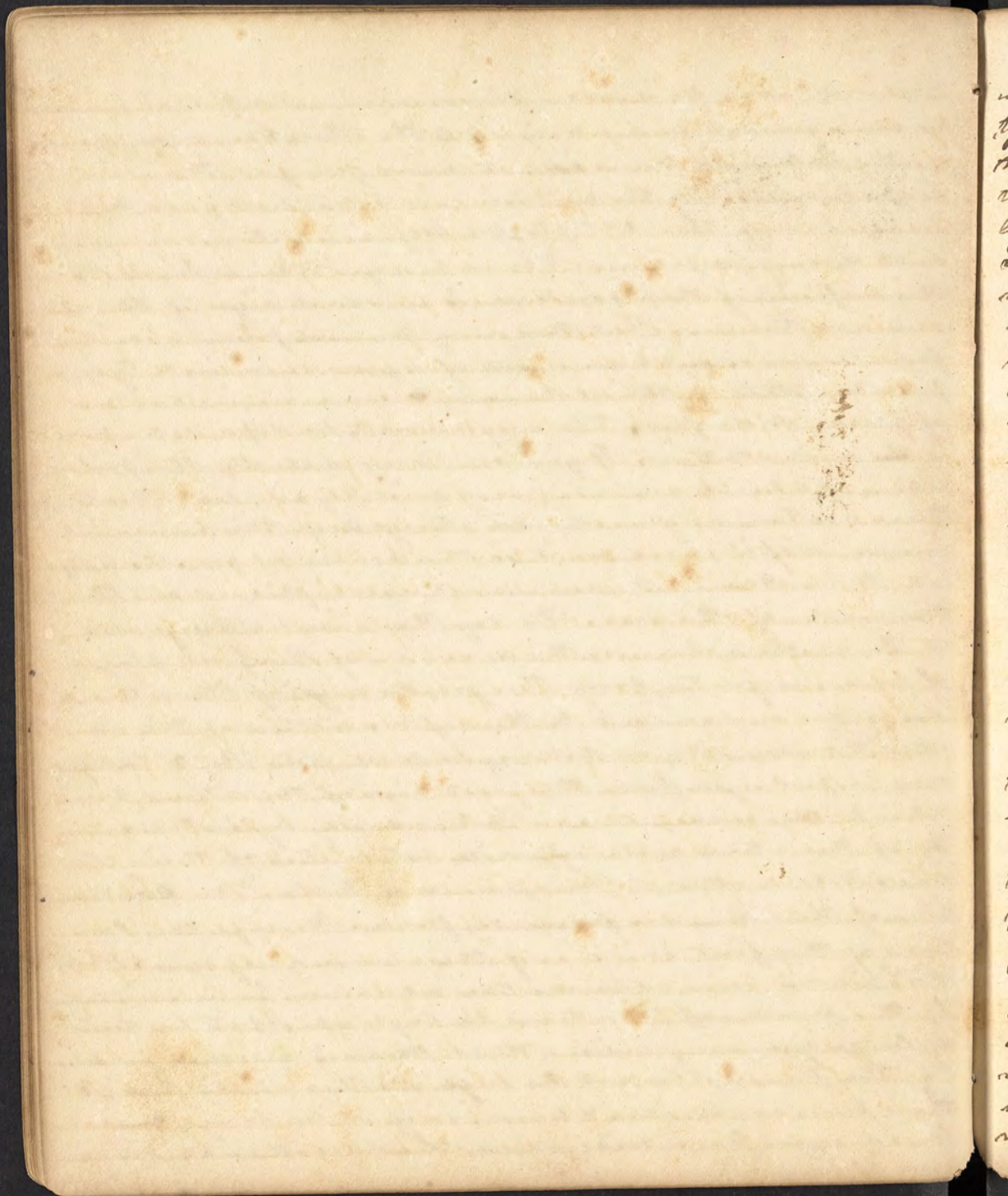
the detachment of the placenta the mother is exposed to uterine hemorrhage, & from the rupture of the cord the child may bleed to death. - Along cord from the looping of it around portions of the body of the child offers the same impediments & dangers that the short cord does. Besides these, the cord may prolapse or come down. You should disentangle the cord from the child's body, whenever it is looped around it, & when there is prolapse, if it is discovered ~~before~~ before the rupture of the membranes, push it back into the cavity of the uterus as soon as they rupture, with the fingers or otherwise. A gum elastic catheter, by tying the cord to the stylet when it is introduced & pushing up the end into the uterus, & then with drawing the stylet, will be often of much service. Sometimes a little pocket of linen fastened on the end of a whale bone, will assist in accomplishing your purpose. Sometimes you cannot succeed in keeping up the cord in this case, the best plan is to deliver the child rapidly. Though it will then be in a state of asphyxia in most cases, you can generally succeed in restoring it. - It is important to remember that the cord is sometimes ~~too~~ quite short. Hence you will not carelessly remove the child too far from the mother before, it is tied & cut for fear of prematurely detaching the placenta.

Complicated Labors Lecture XLVI. March 1st 1/3.

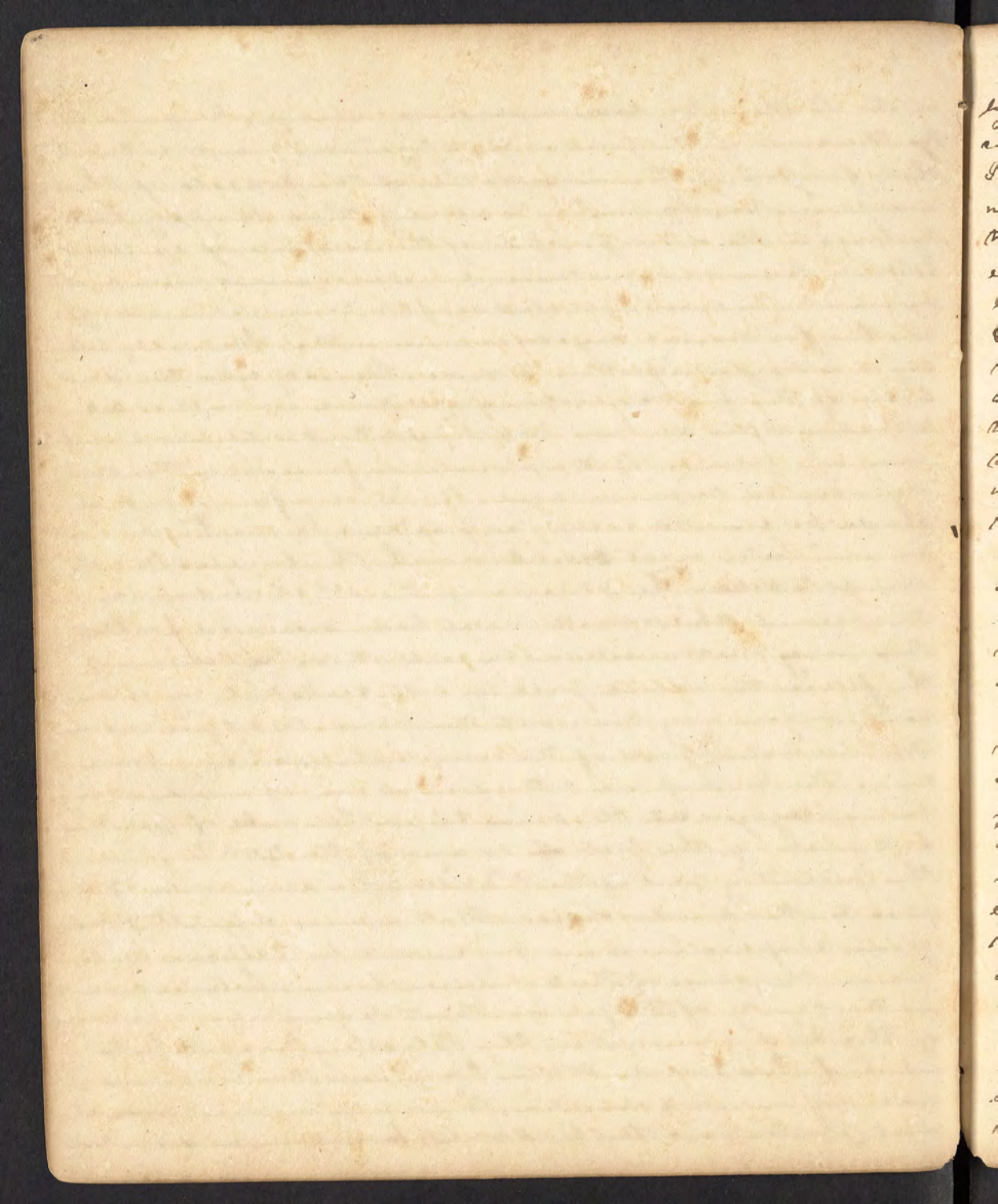
We will now speak of complicated labours. As you are all aware, twins occur not infrequently, though in comparison with the whole number of labours are considered them a quite rare. Triplets sometimes occur but they are more rare than twins. Four children at a time is still rarer. Five have been delivered at one time. Some cases of 6 children have been recorded. When there is more than one child there is a proportionable decrease in their size, so



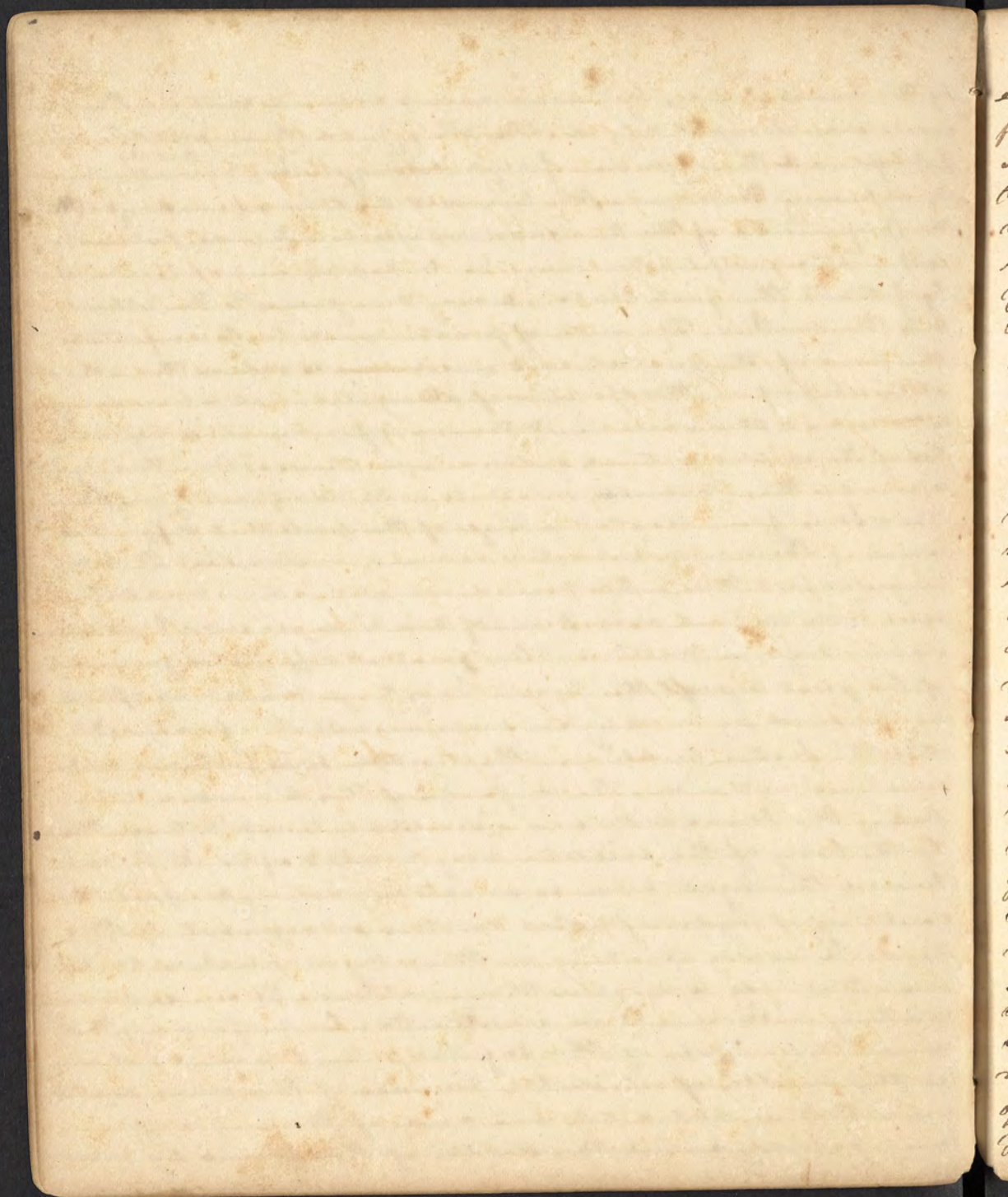
a general rule. We will confine our remarks to twins, since the same general principles apply to the others. Generally speaking the labours with twins is not more painful than in single labours. For the children are smaller & give less pain during the 2nd stage. Diagnosis of twins is difficult during pregnancy. The only sign which leads to the suspicion of their existence is unusual size of the abdominal tumour. But this may proceed from obesity, from an unusual amount of liquor amnii, a tympanitic state of the abdomen, & an accumulation of feces, or dropsy. The only means to be depended upon is the auscultation. If you can hear distinctly the pulsations of 2 hearts you may very correctly conclude that there are twins. You should always keep the woman ignorant of it, because it is the source of greater anxiety to her, & may have a material influence on the termination of the case. We say they may be dangerous to the mother, because the duration of the first stage of labour is greater, from the greater size of the uterus being an impediment to the rapid dilatation of the os uteri, & consequently inertia may be produced. The 2nd stage may be prolonged from the great size of the uterus, & inertia be the consequence. - Twins usually lay in the cavity of the uterus with opposite extremities of their ellipses to each other. - Management of twins. The Contractions of the uterus are frequently feeble. Manage the labour of the first child as if there were only one. After that child is born, examine the abdomen immediately. If the fundus of the uterus be high up, if it be hard & large you may believe that there is another child. If the fundus be not as high as the umbilicus, & the uterus contracted & hard, or if it be large & relaxed, you have assurance that another child is



in it. If there be ~~two~~ a child remaining, be sure to tie the cord of the first with 2 ligatures & cut between them for fear of the inoculation of the vessels of the two placentas. My advice is at any time to apply two ligatures to the cord for fear of the existence of another child. - Some rare instances have occurred in which women have carried a child, after being delivered of another, for several days or even months. Generally one say it is dangerous for this to occur. Usually after the delivery of the first child pains will come on in 15 or 20 minutes. After an hour has elapsed the practitioner should bring on labour. - If the presentation favourable the labour should be encouraged. If it be unfavourable it should be corrected as early as possible. If inertia come on administer ergot & deliver with the forceps. Do not attempt to deliver the placenta of the 1st child before the second child shall have been delivered for the two may be connected with each other. On delivering the placenta do not pull by both cords but by one so that you may bring out the placenta edgewise. - We will now speak of the complications arising from twins. The head of one & the feet or arm of another may become engaged at the same time. The rule of practice is to push up the feet or arm of the 2nd beyond the presenting part of the 1st child. The same rule applies to other similar cases. - But a more difficult & dangerous complication is one pointed out by Velpeau in which the sides of the 2 children become interlocked in the cavity of the pelvis. About 4 years ago, a case of this kind occurred in the Blochley Hospital, to which I was called. When I arrived the woman was very much exhausted, there was inertia & proal most prostration. The first child had been incarcerated



by the House of Piles, by perseverance & extreme caution I succeeded in decapitating it. The other head (then presented) ^(it being already dead) I performed the operation of cephalotomy on, & finally succeeded in delivering the woman. She however died in a few days. (The preparations of the two children succeeded to were exhibited) — This complication may be looked upon as necessarily fatal to the first child, & very dangerous to the other & to the mother. The rule of practice will be to amputate the head of the first child & endeavor to deliver the other alive. To perform the operation of ~~decapitation~~, it is necessary to viscerate the abdomen & thorax beforehand. — Deformities of the child sometimes cause complications. When the child is smaller than natural in all its parts no difficulty will arise. It is from too great a size of the parts that difficulties arise. (There were exhibited various monstrosities) It is a singular fact that a two headed monster is sometimes delivered with apparent ease. A case of this kind occurred last summer in my own practice. — The greatest difficulties grow out of too great size of the head. Very large heads may often be delivered by making compression with the forceps, & still the foetus be alive. — Hydrocephalous foetuses are sometimes met with. The diagnosis of this is made out by feeling the bones with a considerable interval between them. If the body of the child be very small & after it is delivered the head becomes greatly enlarged one may suspect the existence of Hydrocephalus or other enlargement of the head. Generally speaking in these Hydrocephalous children the body is smaller than natural. Of course amputation will have to be resorted to. In performing this avoid the middle of the sagittal & lambdoid sutures in the middle of which the sinuses of the dura mater are situated, but cut to one side of them, for you may possibly avoid the death of the foetus by mere

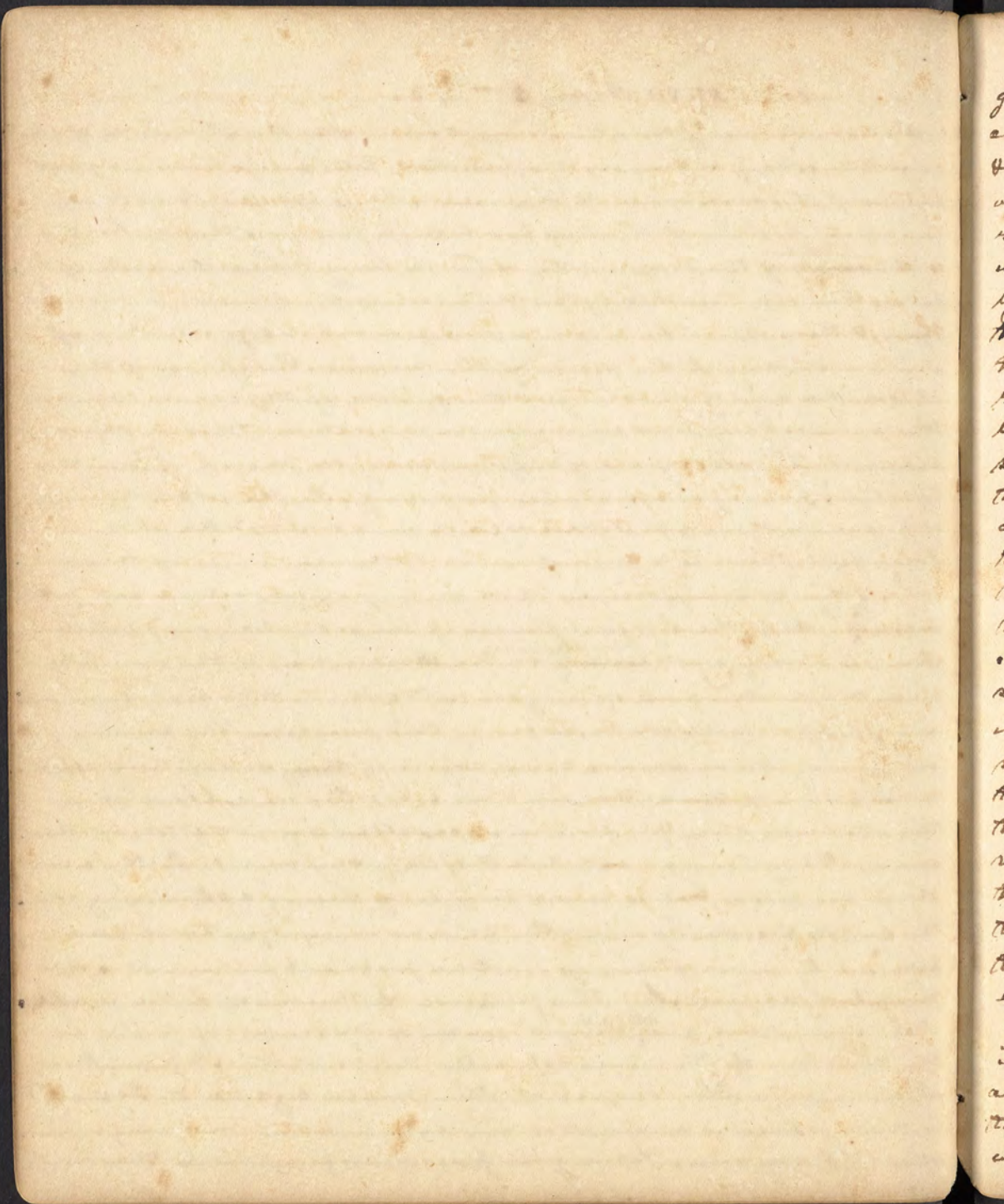


evacuating the water. — We come now to complications
 from displacement of the uterus. The obliquities to the right
 or left may be corrected by ~~the~~ putting the woman on
 the opposite side, & operating gently on the os uteri, per-
 vaginam. ~~She~~ do not speak of posterior obliquities
 because of the peculiarities of the anatomy of the parts,
 yet one may have a bend in the uterus so as to have
 the head resting upon the pubis. These are called sur-
 pulus cases. This condition is ~~also~~ called a retro-
 uterus. The remedy is to push the child's head backwards
~~through~~ (the muscles intervening) & act gently on the
 os uteri per vaginam. — Sometimes there is a hernia
 of the uterus, ^{it may} ~~it may~~ pregnancy in this position. Should
 the child be carried to the full period, it will be neces-
 sary to perform hysterotomy. Sometimes the hernia may
 be reduced in the early periods of pregnancy, or even
 after the membranes are ruptured the reduction be
 accomplished & the child thus delivered per vias
 naturales. Prolapsus of the uterus may take place
 in the first month or two of pregnancy but cannot
 strictly speaking ~~be~~ exist after the 4th month. Some-
 times it may be necessary to resort to the pessary to
 keep the uterus in its proper situation. — In prociden-
 tia of the uterus, it is external & covered with the va-
 gina, the mucous membrane being exterior. If you
 can early, you may push the uterus back. You would
 not be justified in delivering the child prematurely.
 My advice is to put the woman to bed, keep the os
 of the vagina from becoming dry &
 consequently ulcerating, & when labour occurs do
 not permit if possible the bearing down efforts
 of the woman & when the child has been delivered
 you may replace the os.

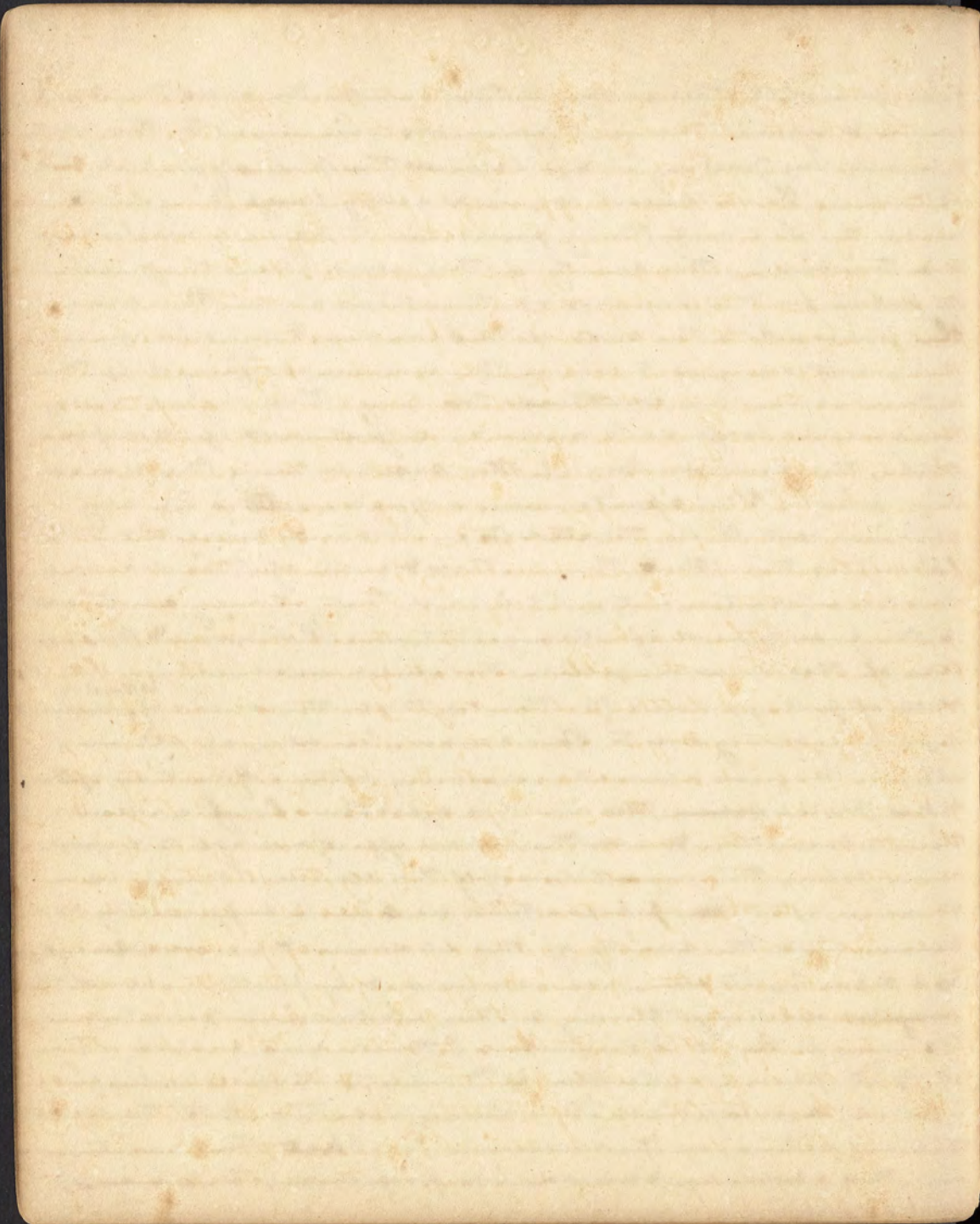
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Lecture XLVII March 3rd '43.

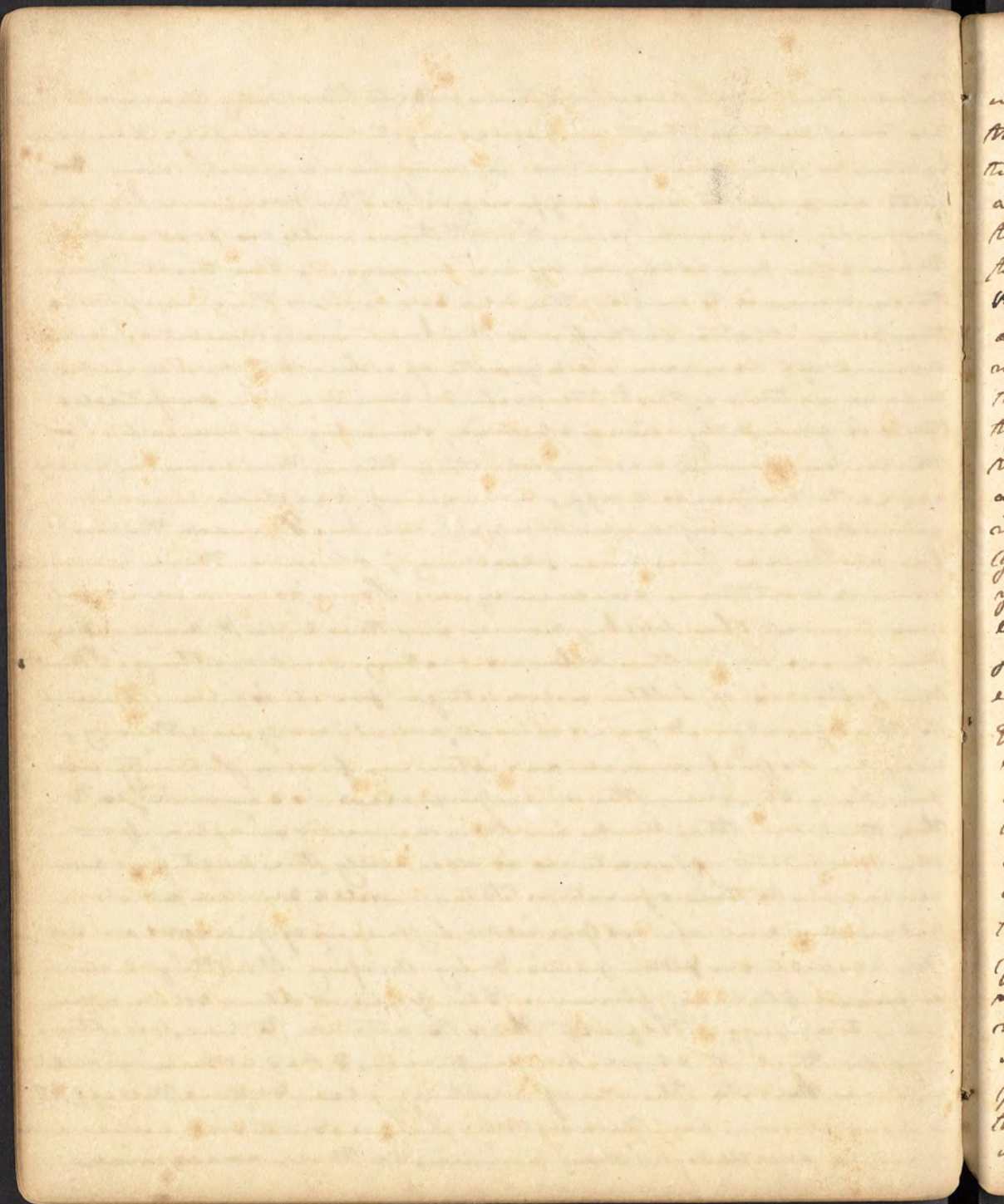
Protrusion of the uterus cannot occur after the 4th month of utero-gestation. Many authors say it is persistent to the full period in a great number of the cases when it does occur. It is defined to be that unnatural position of the uterus in which its fundus is thrown back into the ^{hollow} cavity of the sacrum, the os uterine being behind the arch of the pubis. You must see that by this the neck of the bladder is pressed upon, & there must be in consequence more or less retention of urine according to the degree of the pressure. Sometimes if the bladder be empty you can feel the mouth of the urethra behind the pubis. Many bad consequences result from this in the unmarried female; years of suffering may be passed under this affliction. It may occur during pregnancy. In the 1st & 2nd months of pregnancy there is prolapse uteri to some extent, & the bladder being full there is a predisposition to the occurrence of this malady. I think it impossible that an impacted rectum can ^{do it} ~~displace~~ it. But the sigmoid flexure of the colon being impacted becomes a very great ^{irritating} cause. Relaxation of the round ligaments is another predisposing cause. We know that these ligaments are often painfully stretched during this disease. The exciting causes may be under one head, viz. any ~~thing~~ sudden or violent contractions of the abdominal muscles. Hence a blow upon the abdomen may produce it, also straining, at stool or otherwise. Many women can tell the very day on which the accident occurred, & it is most frequently during a straining when the bowels are constipated. The urine in unimpregnated women is passed by much straining, but in pregnant women it is often totally stopped ^{by} the pressure of the neck of the bladder. The symptoms are ^{severe} ~~severe~~ of pressure, of pain in the direction of the nerves especially the sciatic, & from their stretching in the course of the round ligaments. As soon as the disease is suspected an examination per vaginam should be made. When you pass your finger into the va-



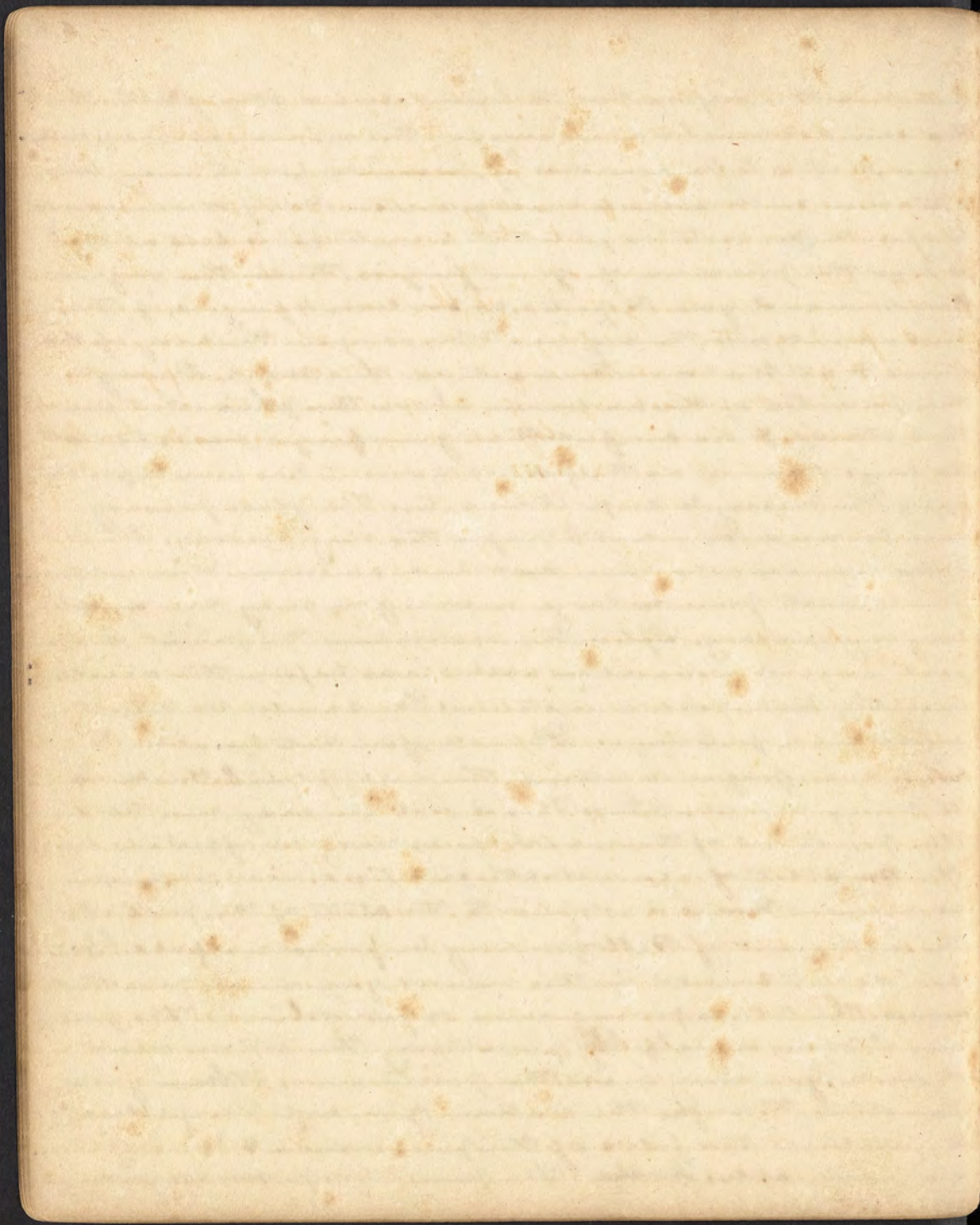
give you feel the body of the woman towards the an-
 enus, & upon tracing it forwards you come to the neck,
 & finally by pushing it up behind the pubis you feel the
 os uterine. Sometimes it requires a very large finger to
 reach it. The only thing for which it can be mistaken
 is a tumour in the cavity of the pelvis. This is diagnosticated
 by feeling for the fundus of the uterus above the arch of
 the pelvis. As to the cure of this you must bear in mind
 the great dangers to which the woman is exposed if the
 retroversion be continued too long. The organ may
 become so large as to render an adjustment of it impos-
 sible, the promontory of the sacrum being the ris-
 ing point. The spontaneous adjustment is in my
 opinion not to be trusted to. — It is only since Dr. Wm.
 Williams's time that the nature & cure of this disease
 has been pointed out. — It is said that it may continue
 to the full period of utero-gestation. Merriam has a
 case of this kind in which the child was born in a
 state of putrefaction. He thinks that the cases of ^{reported} abnor-
 mal pregnancy are to this cause. In almost all in-
 stances they are almost necessarily fatal. Abortions often
 takes place ~~from this~~ in this affection. Inflamma-
 tion ulceration & all their bad effects are apt to super-
 vene from the non-delivery of the child. It may be
 thrown after the ulceration has been sufficiently ex-
 tensive into the cavity of the abdomen & become encys-
 ted there in its own membranes, & by further ulcerations
~~encysted~~ discharge through the abdominal parietes. —
 As soon as ~~this~~ it is discovered I think you should return
 it to its place. After the 4th month it will be diffi-
 cult to accomplish it. Some will trust to the spa-
 ntaneous return of it, recommend that the position
 in the abdomen should be preferred, This is cer-



tainly the most easy position. But the only means to
 be trusted to is that of replacing it immediately. The ope-
 ration is painful, but it is only for a short time &
 puts an end to long suffering. If the pressure be made
 properly no more pain & irritation will be produced
 than can be allayed by an anodyne. The first thing
 to be done is to empty the bladder. For this purpose
 the gum elastic catheter is the best instrument. I have
 drawn off as much as 2 quarts of urine at once in such
 a case as this. Next the rectum should be emptied.
 This is generally more speedily done by an enema. If
 there be more accumulation than the enema will
 cause to be passed off, a dose of castor oil will
 generally accomplish all you wish. Should there
 be plethora previous bleeding; should there be much
 nervous irritation an anodyne. Some recommend a
 position on the back, some on the side, & some on
 the knees with the elbows resting on something. I think
 the latter is of little advantage for it is inconvenient
 to the operator, & you cannot, whatever your theory,
 may be expect much assistance from gravity in
 practice. That on the side possesses no advantages &
 the that on the back in the manner directed for
 the obstetric operations is decidedly the best for con-
 venience to the operator. The muscles should all be
 relaxed as much as possible by means of pillows under
 the shoulders & the penis & by keeping the thighs in
 a flexed state of flexion. The patient should make
 no straining. Request her to attend to her breath-
 ing so that it shall be natural, & her attention will
 induce her to think of nothing else, & thus the effort
 to bear down be prevented. Leewards & others recommend
 bleeding and delirium animi, in those cases ~~which~~



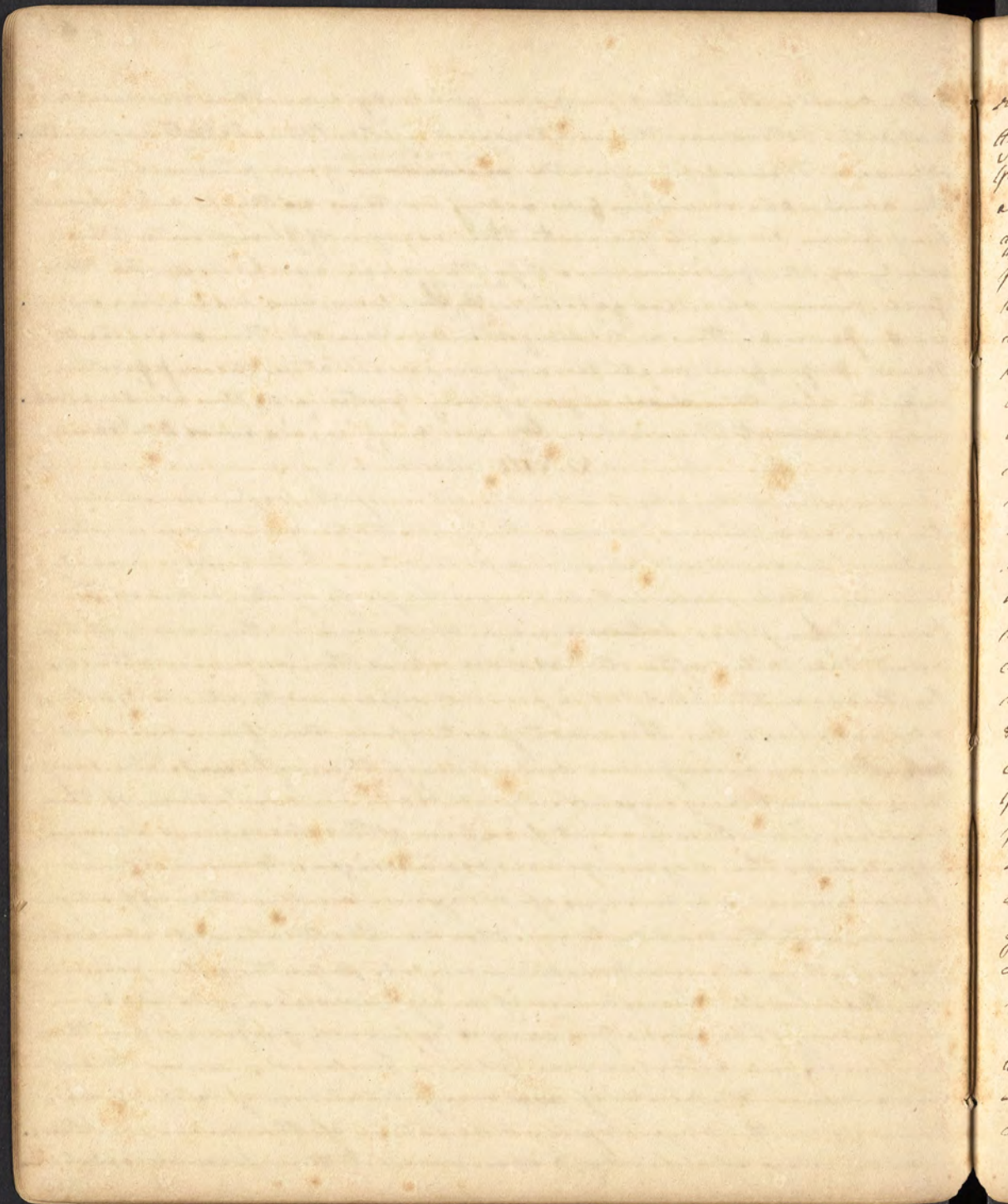
in which the disposition to bleed down is very great. But this can seldom be necessary for the reason already mentioned, & it is to be avoided if possible for it may be attended with serious consequences. — Many recommend to operate per rectum, but the rectum is less able to bear the pressure of your fingers than the vagina. I recommend you to put 1, 2, 3 or even 4 fingers, if the case admit, into the vagina, & press upon the body of the uterus & at the same time act on the os with the fingers. Act gently & steadily & be careful that your finger nails be not too long. As soon as the proper replacement has been effected apply the pessary to keep it in situ. The glass pessary may be used, or what I prefer the ring pessary. For young women who have not had children & in whom you cannot place so large a one you may use an oblong ring pessary. After the restoration the patient is in just as good a condition as she was before the accident, excepting perhaps some irritation. She should be kept quiet for a few days. Should you not be able to restore a pregnant uterus, the best plan I think is to bring on abortion. This is not an easy matter. The puncture of the membranes may be effected by the ~~of~~ stilet of a gum elastic catheter carried in such a manner that it is adapted to the state of the parts. Or the instrument of Pellogue may be found useful. If you do not succeed in this manner you must puncture ~~the~~ per the uterus per vaginam or per rectum. The former I prefer myself. By puncturing the uterus near its neck you may miss the peritoneum. When you puncture through the rectum you are compelled to puncture two folds of the peritoneum & hence it is objectionable. ~~At the~~ The puncture per vaginam



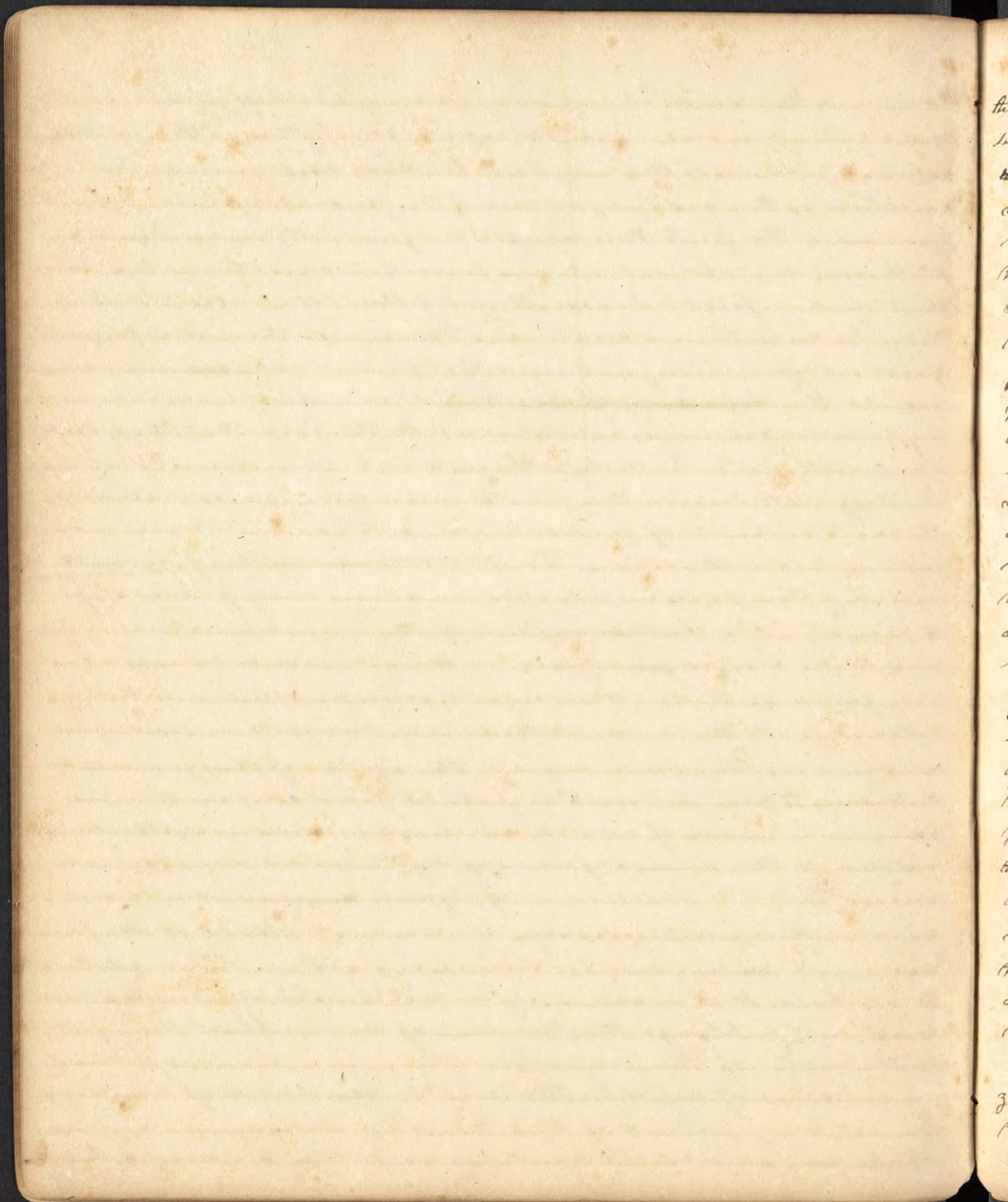
is the best, For this purpose you may use the cannula & silet. Introduce the instrument with the silet well withdrawn. When you operate ^{per rectum} ~~per rectum~~ you should let the cannula remain for a day or two so that adhesions may form so as to prevent the escape of fluid into the cavity of the peritoneum. If the case continues to the full period of retrogradation, ^{any} the various bad consequences supervene, the antiphlogistic system of the strictest kind & perfect rest be enjoined. Watch the opportunity to aid the discharge of any portions of the child which may present themselves by making incisions &c &c.

Lecture XLVIII March. 6th 1843

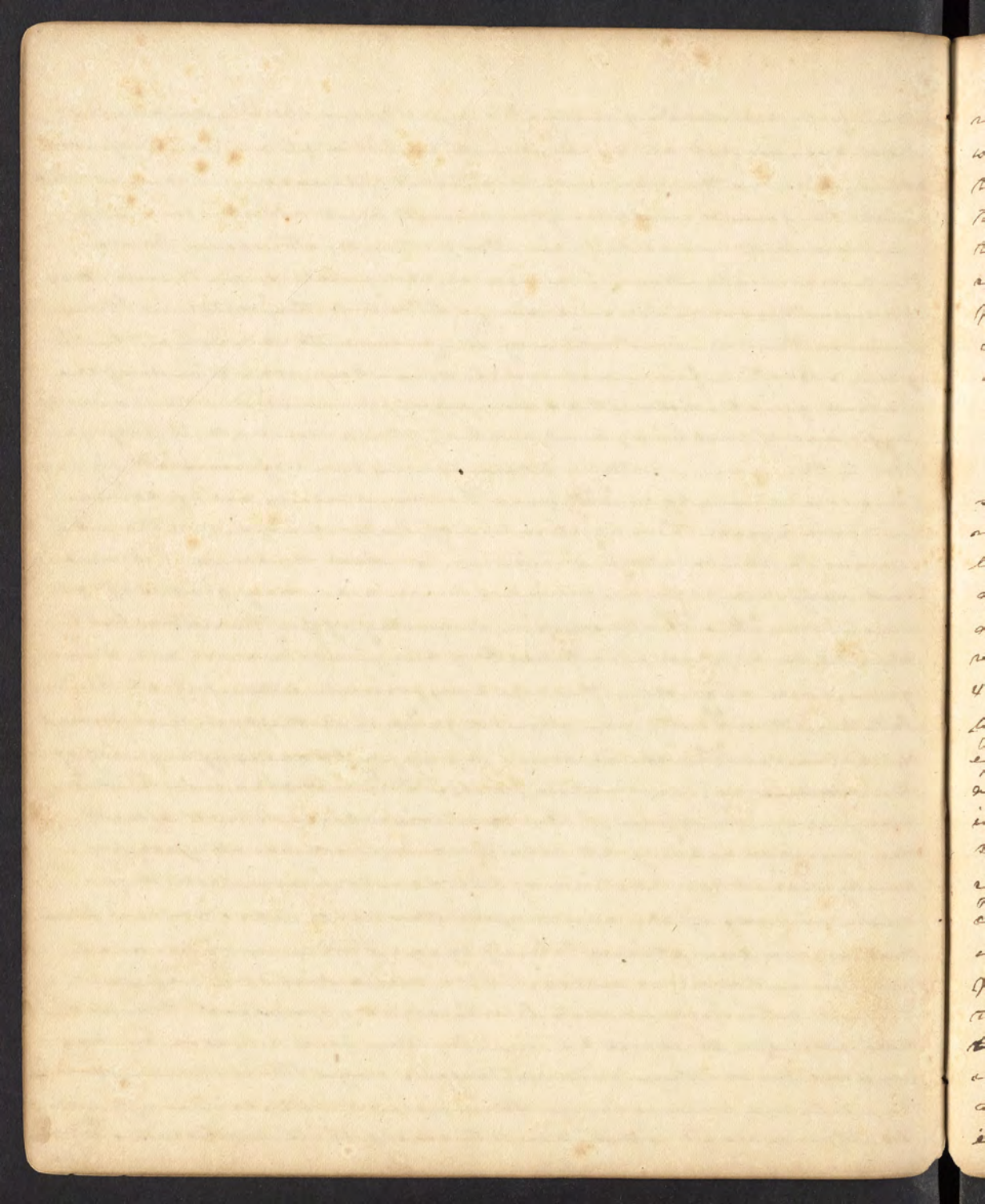
Intervention of the uterus is that position of the organ in which the fundus is thrown against the pubis & the os uterine as is in the hollow of the sacrum. There is a distinction to be remembered between anteversion & anterior obliquity of the uterus; the former takes place ~~between~~ while the organ is in the cavity of the pelvis; the latter after it has risen above the superior strait. In this case the bladder is pressed upon not at its neck always, but for the most part upon the fundus or body. It may arise from distortion of the rectum. The symptoms are not very urgent. There is much irritation of the bladder. Spontaneous rectification of this disease is always effected as the organ increases in size. Coitus per vaginam is a means of diagnosing the affection which is little liable to mislead. The treatment consists in keeping the bladder & rectum empty, & putting the patient on her back. Sometimes it may be necessary to apply a pessary. The globe pessary is generally preferred for this purpose, or a circular one placed for back. — 1843
 I come now to speak of ~~any~~ complications of labor depending on the physiological condition of the woman. These are matters of every day's occurrence & therefore should



receive attention. Labour may be complicated with rigidity
 of all the woman's organs & especially of ^{at the} outlet of the
 pelvis. The causes of this may be set down as, ^{following} a general tonic
 condition of the system, rigour of the general system, & local
 affections in the parts themselves. It is frequently dependant on
 plethora; we almost always find it to a greater or less ex-
 tent during first labours. Among the local affections
 may be mentioned cicatrices. Whenever there is deficient
 secretion you will find rigidity. Hence I believe we may
 ascribe the ~~deficiency of secretion~~ case with which labour-
 ing women & savages are delivered to the fact that they keep
 up secretion. In high life there is not so much exercise
 undergone & hence the greater number of cases meet with
 there. The kind of food which is taken will have an
 influence on the organs. The practitioner by too frequently
 irritating the parts in his examinations may put a stop
 to secretion. Premature rupture of the membranes may give
 rise to it. Crude ~~food~~ ingesta in the stomach & bowels also
 may give rise to it. — When rigidity exists parturition is tedious
 & dangerous to the mother & the child. During its existence bad
 consequences have arisen from the advice of the ignorant &
 pretending to bear down. The patient from long continued
 pain, an increase of anxiety &c., has her nervous system much
 irritated, & the worst forms of hysteria & convulsions may
 arise. To treat these cases of rigidity medical & not sur-
 gical means are necessary. You must attend to the pre-
 disposing & exciting causes. Facilitate secretion. If there
 be plethora st. 3. is obviously indicated. Dr. Denon sur-
 questionably belongs the honour of having first brought
 to the notice of the profession the importance of bleed-
 ing in cases of rigidity. He was in the habit of bleeding
 almost every patient of this kind as delirium arose.
 But you should be cautious as to the kind of acuteness



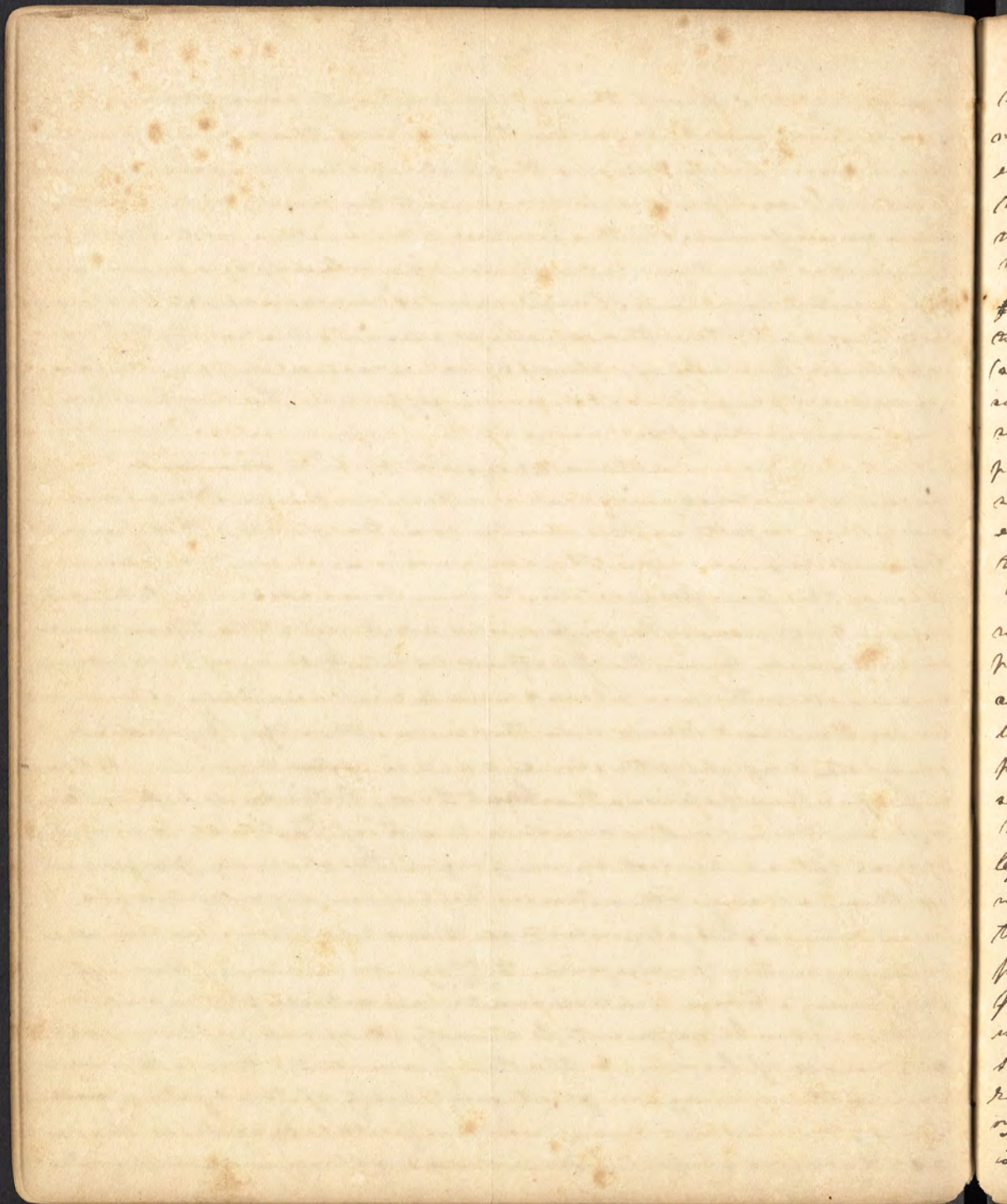
tution you are dealing with. To effect your object you should
 bleed copiously & at once, & not a little at a time. Diapho-
 retics, such as the neutral mixture & effervescent draughts
 will be found useful. You must not allow irritating
 matters to accumulate in the patient's stomach, hence
 the administration of some mild emetics, antacids, &c.,
 sometimes may be necessary. Attend to the rectum. I have
 known the administration of an enema to overcome the ri-
 gidity. Abstain from new irritations. Keep the mind of the
 patient quiet, admit no company, permit her to have
 sufficient of cool air, cool water; the cold bath is prefera-
 ble to the warm bath in patients who are vigorous. Allay an-
 any irritations by anodynes. Fomentations are of service
 in some cases. The application of belladonna or stramon-
 ium to the os uteri is recommended by some. I have
 had only one case in which I have seen any good effect
 arise from it. The medicine is worthy of further trial. It
 should be applied in a tube. Any surgical means are dan-
 gerous, such as cutting the os uteri, forcible attempts at di-
 latation &c. Lastly you should facilitate the regular process
 of labour. — The same remarks apply to cases of rigidity of
 the ~~os uteri~~ vagina & other parts. There is no merit with
 painful contractions of the ~~os uteri~~ which do not affect
 the process of delivery at all. There should be allayed by
 anodynes. — A contraction of the os uteri around the
 neck or body of the child after the head has escaped from
 that organ sometimes takes place. This may occur also
 at the internal os uteri. The remedies are venese-
 ction & antispasmodics particularly opiates. I think that
 an attempt to effect version by the feet would be haz-
 ardous under these circumstances. — Rupture of
 the uterus occurs from the violent expulsive efforts
 of the womb to ~~expel~~ empty itself of its contents. The



use of ergot is one of the most frequent causes of it. It is said to be apt to occur in those who have undergone the Caesarian operation. Rupture of the vagina also sometimes occurs. The pressure against the necks of a practitioner may cause it; the wound of an instrument also may cause it. When these accidents occur we seldom have any premonitory symptoms. Prostration is immediate. The diagnosis is easy. When the child passes into the cavity of the abdomen Gastrotomy should be immediately performed if delivery cannot be at once effected through the natural passages.

Lecture XLIX. March 8th 43.

Labour is sometimes complicated with convulsions. These have not proved as fatal in this country as in Europe. By Puerperal convulsions we mean those convulsions which take place during the puerperal state. Convulsions also may take place during pregnancy. Many females are subject to these convulsions only during the puerperal state & during pregnancy & at no other time. - These convulsions have been divided by LeDucques & others into three varieties viz, hysterical, epileptic & apopleptic, but as it is often difficult to draw a proper line between the last two, I think it better to include them under one head. - 1st of Hysterical Convulsions. These occur more frequently during pregnancy than at any other times. They occur in weak nervous constitutions. Hysterical convulsions occurring in women unimpregnated perhaps owe to their occurrence during pregnancy. There are various ^{other} causes which predispose to them, such as mental anxiety, & moral influences, the modes of living, & the temperament. Owing to various causes there may be great irritability of the system; and among which we may mention (plethora), certain diseases, such as chronic diarrhoea, chronic dysentery, &



hemorrhages. From these & from the mode of living there may be induced such a morbid state of the system that extreme irritability may be the patient's most characteristic trait. - It is important to be aware in your diagnosis of these convulsions. For this purpose attend to the predispositions.

The nervous temperament is marked by a delicacy of appearance, & frequent complaints of unpleasant sensations about the head, twittings of the tendons, startings upon the slightest noises, (as of the clucking of a dove), great anxiety about any thing availing herself or friends, & a quickness of motion. These convulsions are marked by spasms of the large muscles. When the patient recovers from them there is a perfect ^{restoration} ~~recovery~~ to sense, & she is disposed to hide her face as if ashamed. Generally they do not affect the women at all. - The A/poplectic Convulsions are not by any means so easily gotten over.

The epileptic aura seldom or never occurs. The most significant precursory sign is sudden & violent pain in some part; I have known a patient the complaint of a violent circumscribed headache & almost immediately afterwards be in the most terrible convulsions. Dinings of vision, pain in the region of the spinal marrow, & a sensation of tension and fullness in some part are also precursory signs. The character of the convulsions is similar to that of epilepsy. All the muscles are more or less affected, the small as well as the large. The muscles of the face are affected; sometimes one side is in violent clonic spasm, while the other puts on a tonic rigidity. The eyes are also affected, they protrude, & seem to start from their sockets. The saliva is secreted with rapidity, so that the patient may be said some times to foam at the mouth; & the hurried respiration causes sometimes a peculiar hissing noise. The pulse in the commencement is full & slow (being what is called the apoplectic pulse); & afterwards it becomes

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quick & thread-like. There is a stagnation of the blood in some
 organs or organs. The violence of the convulsions may subside
 & the patient be left in a stupified, or somnolent condition,
 & remaining thus she will generally be again attacked, ~~the~~
~~patient~~ The Practitioner should bear this in mind, for some
 are in the habit of leaving their patients at the time he is
 most needed. When she has only one convulsion the recovery
 is generally complete. Upon post mortem examinations little
 has ever been discovered to throw light on the pathology of
 this disease. Sometimes a congestion of the blood is found in
 some of the vessels. During the convulsions no propulsive
 pains occur. Some ladies have happened to have their hands
 in the womb upon their occurrence, & assert that there
 is something like a propulsive contraction to be felt. But
 these are rather tremulous motions of the organ & have
 little effect upon the contents of it. The child is not neces-
 sarily injured. It is ~~more~~ often lost by the attempts at
 version by the feet, & by the delay in the 2nd stage of
 labour. These convulsions are more common amongst
 those who have an abundance of blood. Such persons
 will be found in the higher classes of society; (those who
 eat a great deal & do not work it off). Some ~~have~~ are
 inclined to believe that ~~it~~ ^{they} prevails epidemically; it is very
 true that they are more common sometimes than at
 others, but I think this is to be ascribed to the peculiar
 state of the atmosphere predisposing to their occurrence.
 Indigestion is a very frequent cause. Fear of labour pre-
 disposes to ~~them~~. They are more apt to occur during the
 second than the first stage of labour. And, farther,
 more they are more apt to occur during first than sub-
 sequent labours. — Of the treatment of hysterical
 convulsions we have to say attend to the causes. To
 prevent their occurrence, endeavour to give tone & exer-

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go to the system by the attention to diet, exercise, & the
 mental state of the patient before labour comes on, & care-
 fully attend to the latter during labour. — During the con-
 vulsions I believe that there is more or less of congestion,
 & therefore advise venesection; but you must be careful
 not to carry it too far. You must depend chiefly on anodynes,
 as opium, assafoetida, ether, Hoffmann's anodyne &c. My
 advice is, since the mind is not necessarily affected, to make
 no attempts to bring on labour prematurely. If they occur
 during labour make no attempt to hasten it in the
 1st stage. If the 2nd stage has commenced hasten
 delivery, by the forceps (which is the best plan) or by ver-
 sion by the feet. If you administer Ergot do not give
 it until the second stage has fully commenced, & it
 is best not to do so until the head is in a vertex pre-
 sentation is ~~fully engaged~~ ^{half way} out of the uterus. Some think
 that Ergot does good by causing a metastasis of the
 irritation from the brain to the uterus, it being thought
 that the convulsions depend upon a concentration of
 irritation upon the brain which properly belongs to
 the uterus. — The treatment of apopleptic or epilep-
 tic convulsions requires much presence of mind on
 the part of the practitioner. The attendants are all
 generally as much astonished & frightened that he will
 be compelled to depend on himself to do every thing. The
 first thing is to remove the causes. As it most frequ-
 ently depends on plethoric & a local determination to the
 head, free & copious bleeding should be resorted to, to-
 gether with cold applications to the head. The state of
 the abdomen should be attended to. Stimulating
 enemata will be useful by their revulsive op-
 eration & their evacuating the intestines, (accumula-
 tions in them being sometimes the cause of this con-

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VOL. II.

me to give you more than this more extent of this
 disease. The name given to the collection of
 my annual of lectures. I regret much that more time
 is not allowed me for lecturing. Formerly the professor of
 midwifery was allowed four lectures a week, but
 since the establishment of another professorship, only
 three are allowed for my branch. These during the
 winter given a series of lectures embracing pretty much
 the whole of the midwifery part of my subject, that
 number of lectures on the diseases of the
 men, & during the summer of lecture on the diseases of the
 women. In this way a complete course is given
 something like a full course on the subject. - With
 the expectation of my students for your kind & re-
 spectful attention, & the wish they your many pro-
 fessors be happy in the pursuit of your honorable
 calling & happy in action!

convulsions. The number of times in which it will be necessary to renew the use of the lancet will depend upon the case under your charge. When there is a local pain in the head after free general depletion the application of leeches is proper. You should be careful not to carry the depletion too far for fear of producing an anaemic condition, which favours the effusion of serum into the brain which is as great a source of difficulty as the plethoric. - After the paroxysm you might administer cathartics as Calomel &c. Many & especially Dr. Laws are amongst the number) think that you had as well shunt the patient in the head as to administer opium or any of the anodynes, but there can be no doubt but that opium is of great service in many cases. - The advice given concerning the delivery in the hysterical variety is here also applicable. There is much discrepancy of opinion on this subject. Many, very many & some too of high authority in the profession think that delivery should be effected speedily & possibly if not otherwise. Some go so far as to advise that the ^{width of the} ~~per~~ ^{uterus} be incised in order that the delivery be effected when the 1st stage is as not sufficiently far advanced. I am decidedly & emphatically opposed to this. And if I have any influence with you I entreat you not to resort to forcible means of delivery. The presence of the child is not a great source of irritation & would be the contusion & laceration of the soft parts of the mother, & besides this you are unnecessarily sacrificing the life of the child. You should keep the patient quiet & prevent the presence of any source of irritation either physical or moral during convalescence. When there is not a perfect return to sense you will well and not unfrequently have to contend with another paroxysm. - It can be as

dangerous, and perhaps it is a sign of the recovery
of local inflammation. - During the discharge
which in the vagina & uterus, giving the usual
lying in room a considerable. In this case you
must observe the progress by means of examining
or 2 times a day. When the lochia continue to
flow as long as the weakness of the patient, you may
administer as long as the patient is weak. When found
prolonging the answer in most cases, some recom-
mend to try it with a view to produce contraction of
the uterus & thereby put a stop to the discharge.
Give any stimulant & nurse like to heat, of
course an outline of it being upon the fire is not from
the numerous works which have been published
on the subject of lochia purgation but not seem
to be worth the trouble of examination to be men-
tioned. One when there is extensive inflammation it is
one of the most common & dangerous diseases in all medicine
Gonorrhoea is not so dangerous as gonorrhoea as often
terminates in suppuration. There is again another division of
the affection into chronic & epidemic gonorrhoea. The
disease generally commences with a chill, and a dis-
charge before or after or simultaneously with the pain. It is
the same part of the abdomen when pressure is made.
The urine is greatly affected by heat & this is the
indication for not reduced of the patient will sink
under it in 2, 3, 4 or 5 days. - If the urine is not
checked upon is bleeding it must be done soon, & repeated
as soon as the system recovers. It must be carried as near
by as the patient can, in cases of hemorrhage. After bleeding
freely give opium, & laxatives. By the latter occasion
no the heat. Against these may there will not per-

been for sometimes under my charge which it may be interesting to relate as it shows that these convulsions may occur under circumstances somewhat dissimilar to those mentioned. - The patient 3 days after delivery had a violent paroxysm of epileptic convulsions. - During the 6th month of her next pregnancy had another, 8 months after this she had an attack of spasmodic cough, having escaped the convulsions, 9 months after this another paroxysm of convulsions. She for several months continued to have a return of the convulsions, every 3 or 4 weeks. She had a copious supply of milk, & has now escaped for sometimes her regular paroxysms since she weaned her child & ~~has~~ been kept upon a tonic & supporting diet. - It should be borne in mind that as bearing down predisposes to convulsions, it should be avoided. Patients should not be permitted to hold their breath for a long time as it may cause congestion.

Lecture I. March 10th 1843.

Inertia of the uterus means a want of action in its muscular fibres. A distinction must be drawn between want of action & want of power; the former may exist with a sufficient amount of power, & hence one may bring it to operate by stimulation; the latter implies weakness. We may have a want of tonic contractions, or of dilating contractions, or of expulsive contractions. It may exist in the different stages of labor, in one & not in the rest, or in all. Some persons are peculiarly liable to it. On what the precursivity depends it is difficult to say. The size of the uterus favours it. If it form any cause as a great quantity of liquor amnii or size of the child, it is large, & you will find that the proportion as it is diminished, so will the powerfulness of the contractions increase. Plethora either general or local is a very frequent cause. Nervous derangement may produce it. Others in

after an effort with - since the active nature
 directly. - I am so much that slight cause
 will excite the nervous system, & that there is a
 great feeling of the system during the
 period of the state. When we do not permit things
 to go on as they should, we may be very active in our
 own solution (the nervous system), to make any
 effort. They are quiet, first among the nervous
 for we a due early sufficient to keep the system
 all from annoying us. We rarely do not need
 maintenance of the nervous system of force of sleep
 may be put to the great early after its delivery of the
 matter be not the most exhausted. In fact we do
 long as you should not be putting it to the great
 (there is necessary both for the matter's & character's
 well-being. If the action of matter is not greatly longer
 in any manner - action by the present system
 action of the state to the night. But the end of the
 day you may have the matter going. This is to be made
 broken by action medicine. It is always best to have
 the matter put at the time of the system going by
 way of prevention. - Inflammation of the throat is
 not to be treated on the principles of prevention, but
 by application to the part itself, as prevention.
 Quinine, quinine, leeching, leeches &c. The reason
 action of the matter is not important, it is not to be
 by the chief part. Things may be necessary, or
 by means of a bottle, or a person's attention to the
 matter may be put at rest, or by either of these &c.
 - The thing is of the nervous system, which
 continues for a number of years after delivery. When
 action of the nervous system is not to be considered as

Those persons called hysterical it is extremely apt to occur.
 When there is severe pain in the head, in the chest, or abdomen
 or any other portion of the body, there is apt to be no pains in
 the uterus. This is ascribed to metastasis of irritation. Various
 affections of the uterus are said to cause it, as cancer, incantrics
 &c. But I have never had a case which was brought on by
 them & doubt very much whether it is often the case. Dur-
 ing the 1st stage ~~the~~ neither the mother nor the child are
 much affected by this occurrence. The labour is rendered
 more tedious. The same is the case in the 2nd stage with
 the ~~same~~, but, for there is no pain & the child's life is
 not endangered by pressure. Labour may last several
 days. Nervous patients, however, are apt to suffer from
 anxiety. In the 3rd stage, there is tonic & expulsive
 inertia, & there is danger of profuse hemorrhage, & an
 speedy death from it. If the patient be plethoric, ~~there~~ ^{she is}
 & the pulse excited she is liable to lose the loss of more blood
 than one who is weak & nervous. It is therefore impossible
 to say how much blood the patient may lose on these
 occasions, without a fatal termination. In some persons
 from some cause ~~next~~ known there is always more or
 less hemorrhage after delivery. - Patients very often
 die from occult hemorrhage. By this is meant hem-
 orrhage in which no blood runs out externally. The
 placenta being detached, & there being inertia of the
 uterus, it is not expelled, but plugs up the mouth
 of the organ, & large quantities of blood are poured
 out into it without the practitioner suspecting the
 cause. Clots of blood may do the same thing. Or
 the placenta or clots of blood may remain in the
 vagina & thus prevent the escape of the blood ex-
 ternally. The child is not endangered, in in-
 ertia of the uterus unless by the operations to which

the practice first of all must be applied not to
figure or calculate or separate it more than you
can help. Patients will often answer readily
extreme treatments. There be much previous
exhaustion. They are not practice of introducing a
kind of as a foundation & gradually with draw
ing it as the case proceeds & the circumstances
require is worthy of twice & will be successful
in many cases. — Of the complications of a
burn proceeding from the disease of the mother
I can say but little. This must be left to your own
judgment aided by the knowledge of your pre-
vious generally when you have acquired from
other experience there! It may be, but of
little with the same disease at the time of
labor which may affect her at any other pe-
riod. — There may have been aneurism. Or
of fracture. This case is to permit the physi-
cians naturally, & in the 2nd stage to de-
linee carefully so as to prevent the burst-
ing of the aneurism from bearing down, but
my life is, the same rule is to look
ahead in case of disease of the mother lungs,
or when there is a hernia!

I have but a little time to write a few
observations on the management of women
during the puerperal state. — I have been your
patient with reaction some place. — Return &
as her within a few hours; not more. Then
12 hrs, at the farthest should elapse. Return
in a company her own efforts. Engage her to the
state of the breasts, & the modulation of the
have not passed, however, & I give it as so

it may be submitted for the sake of the more valuable life of the mother. Another consequence of inertia is inversion, this may be complete or incomplete. In the complete variety there cannot be strangulation, in the incomplete it may take place from the contraction of the circular fibres. The exciting causes of inversion are various. The most frequent is pulling at the cord, ~~until~~. He who you should never make traction with the cord until the uterus contracts. In fact any force applied to fundus will cause inversion under these circumstances. Some think that the weight of the placenta sometimes causes it. But if the woman lie in the recumbent position, & especially on her ^{side} ~~back~~, I cannot but think that it would not have this effect. But if she stand or sit up it is very readily conceived that such a consequence should follow. The voluntary bearing down efforts of the mother may produce it. By the inversion the placenta is usually detached, the patient immediately in a state of syncope, profuse hemorrhage results, inflammation, sup-
puration & ulceration, & even mortification of the organ takes place after its restoration. The incomplete is more dangerous than the complete variety. From strangulation of the invested portion one may have profuse hemorrhage from the veins, (the blood being prevented from returning by them & the arterial supply not being cut off) or the strangulation being more complete one may have mortification & sloughing. The diagnosis is made out by an examination per vaginam. A tumour is distinctly felt. That you may not mistake a polypus or similar tumour for it you should feel on the abdomen for the uterus & finding ~~the~~ hollow there you may be pretty sure as to the state of the case. Of the treatment of inertia in the 1st stage we may be not in a hurry. Attend to the state of the patient's mind. Do not permit her to be too anxious. Let her walk about now & then encourage her ^{since} it will not be attended with any great danger. But some times it depends on causes which

so often is not directed at all as a last resort. For some
 thing of this nature, the President. When nothing cannot
 be effected he cannot the system will not direct
 direct on the moral means, ~~the President~~
 the President has better know the moral
 count of the policy to make the more we
 out the President. This is clear in which you
 may trust to the long not understanding the great
 we have for it administration, for it is better
 to him the risk of it administration than for
 not this reason to the immortality. When
 the situation does not take place as rapidly &
 enough on the way sometimes he often by his
 during the time of the chief in the country of the
 states. - When the President presents over the state
 in the management during (preparing committee in
 during the President, long & must account by a

Monday, & in preparing the most perfect
 to get, with the interest measures of them of;
 (When there some in, and the President during
 the 1st stage. There is here no necessity preparation of the
 members. Do not seem your position during this stage.
 Do not make forcible efforts at doing. - In the 2nd
 stage surgical means on any official. Orders are quickly
 by a President clear out the entire completely. - Of
 the management of the stage in the 3rd stage
 it is not necessary to speak, as it was sufficiently de-
 tailed in the history of the President.

Lesson IV. March 18th, 1843.

After disposing finally of the subject of the President
 President, things are made to appear that in relation
 any your lesson to deliver something you will not

may be removed. Thus when upon plethora the action may be restored venesection, when upon flatulence by cambricatives, when upon nervous excitement by anodynes especially opium, Warm Herb-teas as ^{of} mint, saturej, sage &c when the inertia is slight will often overcome it. Stimulating enemata are also very useful; putting the feet in warm water sometimes acts favourably. During the 2nd stage of labour the treatment is essentially the same as in the 1st. Bear in mind what was said about plethora, & local congestions. There can be no objection to the rupture of the membranes, if the presentation be favourable, for evacuating the waters by diminishing the size of the uterus is of great service. This water may be gradually evacuated by inserting the finger between the child & the uterus. This is the case in which ergot is useful. Five grains will bring on the powerful ergotic contractions usually in about 10 or 20 minutes, but you had better give the full dose viz 10 or 20 grs diffused in water. The ergotic contractions are very powerful & steady, with very slight intermission. It is very dangerous if not given with judgement. If or the time it has been in use I have no doubt but that it has slain hundreds to one who has perished by the use of the forceps & other instruments. But I am not one of those who would wish it to be condemned altogether on account of its abuse. It may cause the death of the child by pressure upon it or upon the placenta or upon the cord. It may cause the mother's death by rupturing the uterus, or contusing & lacerating the soft parts. You should never shrink it unless the os uteri be dilated, & when there is much mechanical resistance to the free passage of the child, as from contracted pelvis, tumours, rigidity of the soft parts, & especially of the perineum. My own practice has been to bring on contractions by stimulating enemata & the other means

[illegible]

mentioned & deliver with the forceps: - In inertia during the 2nd stage there is much danger. No one is justified in trusting to the spontaneous occurrence of contractions. Quick. The coagulation of the blood is not to be depended upon to prevent hemorrhage, on the contrary its accumulation in the uterus is a cause of hemorrhage. Palmar always succeed by producing evacuation of the uterus, & by putting the hand inside of the organ & stimulating it by its presence. This very rarely fails. In the ~~West~~ Indies they introduce a lemon deprived of its rind & squeeze it. In the same way a sponge dipped in vinegar will be useful. Cold water poured from a pitcher, or a cloth wet with cold water & placed on the abdomen will often effect your purpose. The placenta should not be removed until there is a disposition to contraction. The occult hemorrhage should be borne in mind, coagulated blood may fill up the whole canal from the fundus of the uterus to the vagina. Do not depend upon this to put a stop to the hemorrhage for it is a cause of inertia. The tourniquet would operate disadvantageously. Every coagulum should be carefully removed, & sometimes this must be done more than once. You may put your patient on tonic & nutritious diet, or give stimuli to produce reaction. Never leave your patient until reaction takes place for not till then ^{can} you ~~be~~ consider her safe. This will be indicated by a return of warmth to the skin & a restoration of perspiration.

Lecture II. March 13th 1843.

Retention of inversions of the uterus. Nature here can do nothing, the practitioner is the sole dependence. Request the patient to suspend her bearing down efforts. Push the fundus back in the direction of the axis of the womb, & keep the hand in the cavity until contraction takes

The medicine pointed out in the last lecture there is a
 peculiarly of great importance by recognition. The
 action shown is frequently the consequence of the pro-
 portion of the placenta. — Great hemorrhage occur-
 ring during pregnancy is very rare. It is the least at
 first is always changed. This is almost necessarily the case
 in account of the tenacity of the uterine. There may be
 some difficulty in diagnosis; for many factors to a
 patient who is exsanguine, is probable, there is a
 than & signs etc. The only assistance to be depended
 on as any thing like decided are sensation & feeling
 of weight & pressure in the uterus or its neighborhood.
 This prognosis is very unfavorable. The only hope is
 that surgical contractions may come on & expel the
 ovum. — When there is profuse hemorrhage in the
 1st stage of labor one says that it is coming to detach-
 ment of the placenta, notably or in part. It is not then
 merely may occur from some other cause. The most
 danger from the first cause in this stage may say to an-
 avoidable. It is dangerous to the mother, but also to
 the child just in proportion as the placenta is sepa-
 rated & the length of time spent in its delivery. The
 occurrence during the 1st stage is not necessarily pro-
 portioned to the following ~~stage~~ in the 2nd stage some occur-
 men of profuse in the umbilical cord during in the
 second stage in order that hemorrhage may be stopped
 (This manner is doubtful practice. — In case of pla-
 cental presentation we do not consider the patient
 as safe until the uterine is emptied. In relation to
 this case once occurred in my practice in the case
 of a blacksmith's wife in the Northern part of the
 city. After bleeding profusely the hemorrhage

place, so that you may be assured that the accident will not recur. If you are present at the time of the accident, you may almost always succeed in effecting the replacement. At any rate, always make the attempt. You should not stop to detach the placenta, but push it up also, for delay is dangerous. If you do not succeed you may ~~detach the~~ ^{detach the} placenta, & make further attempts to restore it. The incomplete variety is more difficult to restore than the complete. When the restoration cannot be accomplished ~~unless~~ ^{except} the hemorrhage by cold & astringent applications. Relieve the pain by opiates. Prevent irritation by restoring the uterus into the vagina, & if necessary use a ^T bandage to keep it in its place. Pursue the antiphlogistic plan, give rest, & absence from excitement of every kind, physical or moral. Dr. Denes advises that the incomplete be converted into the complete to prevent the consequences of strangulation. — Labour is sometimes complicated with exhaustion. By exhaustion is meant a want of power. This may be general, or only confined to the uterus. The causes of it may be the common ones of exhaustion, as various diseases, hemorrhage &c. If hemorrhage happens to occur during exhaustion it is very dangerous. Syncope is a very dangerous symptom during exhaustion. The treatment of exhaustion varies according as there is or there is not hemorrhage. When there is hemorrhage, deliver the woman immediately of the child, and you will afterwards be able to treat her for the hemorrhage & exhaustion. When there is no hemorrhage you ~~may~~ ^{should} put off the delivery, & give tonics, diffusible & permanent stimulents, & prescribe a nutritious diet. Quinine, opium, brandy &c. will be found useful. — Some authors speak of syncope complicating labour. But it is merely a symptom. When a symptom of exhaustion it is

stage of labour or at any period of pregnancy. Without
 going into any detail about it, suffice it to say that the same
 general principles apply here as have laid down when
 treating of that subject. The common principles of surgery
 will apply and the hemorrhage with a few exceptions apply
 here also. These principles of treating cases maintain
 as modern surgery, hemorrhage, will maintain & exist when
 or by the contraction of the uterus the same is de-
 tailed in some part of the uterus the principles of the
 same maintained. No diagnosis we say it is in general
 very easy, for it is rare that the treatment taken should be
 such a manner as not to permit the blood to flow out,
 & make it appear as at the so extensive. The manner
 which nature uses the hemorrhage is by reorganization of
 blood. Nature often thus makes a means to recover
 from the hemorrhage & escape death as the first pe-
 riod. - The hemorrhage being once commenced in the
 organ there is in most by the pain, which they cause
 a detachment of a larger portion of the organ. But after
 the organ is detached hemorrhage is permitted by con-
 traction. Now in what is called the static period
 'hemorrhage' is more hemorrhage, contraction
 'hemorrhage' or time will not permit
 details in this only is, from nature it after a few
 days time for you to act upon general principles. - On-
 ring the 1st stage of labour, or during the pregnancy
 there may be hemorrhage arising from the attachment
 of the placenta too near the neck of the uterus. This is what
 is called immediate hemorrhage. You must be care-
 ful in your diagnosis, you may feel the margin of
 the placenta near the neck of the uterus. Sometimes
 in order that you may not ^{out} a great diagnosis the
 whole hand will have to be passed into the vagina.

almost always fatal. When a symptom of nervous irritability or weakness it may always be overcome by the administration of an anodyne. Some women faint in the commencement of labour upon the occurrence of the first pains, ~~But~~ this disposition ceases when the powerful pains come on. — Hemorrhage besides occurring in the third stage of a regular labour, may occur during either of the other stages, & at any period of pregnancy. We speak of hemorrhage occurring during abortion, or when the ovum is delivered during a period preceeding the end of the 6th month, of hemorrhage during premature labours, or those which occur between the end of the 6th month & the full period, & of hemorrhage occurring during the stages of a regular labour or at full term. — As the subject of abortion is intimately connected with that of the first variety of hemorrhage I will treat of it first, endeavouring to separate it from the other as much as possible in order that I may make this subject intelligible. Children are generally viable after the end of the 6th month, but they have been known to live ^{born} during the 6th month. The practitioner should therefore not neglect to make the proper efforts to preserve the life of the child, during any month as the precise time is uncertain. Abortion may commence & not be ^{completed} ~~definite~~. There can be no doubt but that partial detachment of the membranes may take place & still the ovum be preserved to the full period. It is an unsettled question as to whether detachment can take place without contraction of the uterine fibres. That abortion may be brought on by various means, is brought forward in support of the affirmative of the question. But on the other hand it is contended that the irritation is caused

now already there. But it may also occur during any
 summer or winter. The place during the 3rd stage -
 from the present as in common cases. — Of the
 this stage, you must also facilitate the change, & take
 at first from. You may be so with advantage as
 from the application of the force is more dangerous
 operation of action by the first is very dangerous. ^{from the} 1st
 in the 2nd stage, since the action is not fully developed, the
 this symptoms, do not allow learning alone efforts. —
 be resolved to. — When following only begins moderate
 great. It is proved from previous observation that
 of night & morning should be delayed by smoking
 being being little pain in the pulse or lower, or any other
 kept off existing cases. Others in the region of lower,
 motion between action to the producing a cure & a
 from ~~the present~~ from so moving. — The present pre-
 germination (that is 4 months) either to avoid either to
 since the more greater to its chance of living, (the more
 operating to produce a cure. — The more motion the
 cases are similar to those already observed as
 easy passages understood) the producing & existing
 then it offering no mechanical resistance to its
 stage is short on account of the small size of the
 month but not completely until at least. The 2nd
 which as you know does not commence until the 5th
 occurs by for the observation of the work of the month
 in general the 1st stage is longer on account of the
 relations either on the subject of regular lessons.
 symptoms of pneumonia lessons are very similar to those
 not therefore entirely similar on this subject, and
 action will depend on the position of the case. Since
 with the same & extract it. — The treatment of the
 now that they will never give in most instances to

any one

in the uterus, which is followed by contraction. - The causes of abortion may be divided into those which depend upon the ovum, & those which depend upon the ^{state} mother's system generally or upon that of the uterus alone. - Generally speaking when the embryo dies the ovum is expelled. Yet after its death it may be absorbed & the membranes alone remain together with the placenta, they being nourished by the vessels of the mother. M^r. Burns believed that such ova are to be met with which have never contained an embryo. But in every case where careful examination is made it may be clearly proved from the remains of the ~~ovum~~ ^{foetus} &c that its death exist. The vulgar idea about false conceptions is wrong. A diseased condition of the ovum & its membranes often cause abortion, as thickening from granulations collecting on their external surface, bunches of cysts &c. Of the diseases of the ovum we cannot know ~~any~~ ^{anything} about until it is expelled. When abortion depends upon the diseases of the mother or of the uterus alone the best means of preventing it is to attend to the causes. A nervous temperament, instability of the system proceeding from particular modes of living, & certain habits, or asthma, or plethoria, agitation of mind, & various diseases tending to debilitate may be put down as predisposing causes. - An inflamed uterus also predisposes to it. This may be caused by displacement (~~retro-version or ante-version~~). Plethoria of the uterus also predisposes to it. Hence abortion is most apt to occur at the menstrual periods. Cancer, scirrhus, or inflammation of the uterus, diseases of its appendages particularly the ovaries, or vagina, may be noted also. - Many of the predisposing causes may be strong enough to act as exciting causes also. Mus-

propriety into the region and there not come
 to the so extending the milk region the aid of
 the academy. The Academy will purchase
 to obtain. The whole power may remain in the
 hands of the officers. But correspondence must be
 made necessary. The one thing is clear upon
 sometimes to arise in the exhibition, or by our
 own efforts to extract. Your efforts to sell
 no doubt the union when it is in the region.
 allowing ourselves when the union is to remain
 alive are your shoulders the fingers in the fact
 thing of this case to show without doing this
 much violence. When you are not successful in
 this may you have some introduction of
 a campaign into the matter of the matter to exist
 preparation going. But I cannot but think this
 a dangerous practice. I hope may bring you into
 be sure of it to be in any way in your exhibition
 of this effort but these when the nation is long
 as at first time. If possible you might to be
 the union, of this in some way at the time
 you must not want. If there is no necessary
 you may improve. Or some more for extract
 from a long article or book. I have heard from
 interested in this movement into the union, I have
 been an object of its doing in the fact I have
 may feel quite certain of its introduction. I have
 without any something more interest. I have
 English for something to see the effect of
 would but point that the work of the union
 activity across the union. I have quite good
 one organization for the union. I have
 another the situation for the union. I have

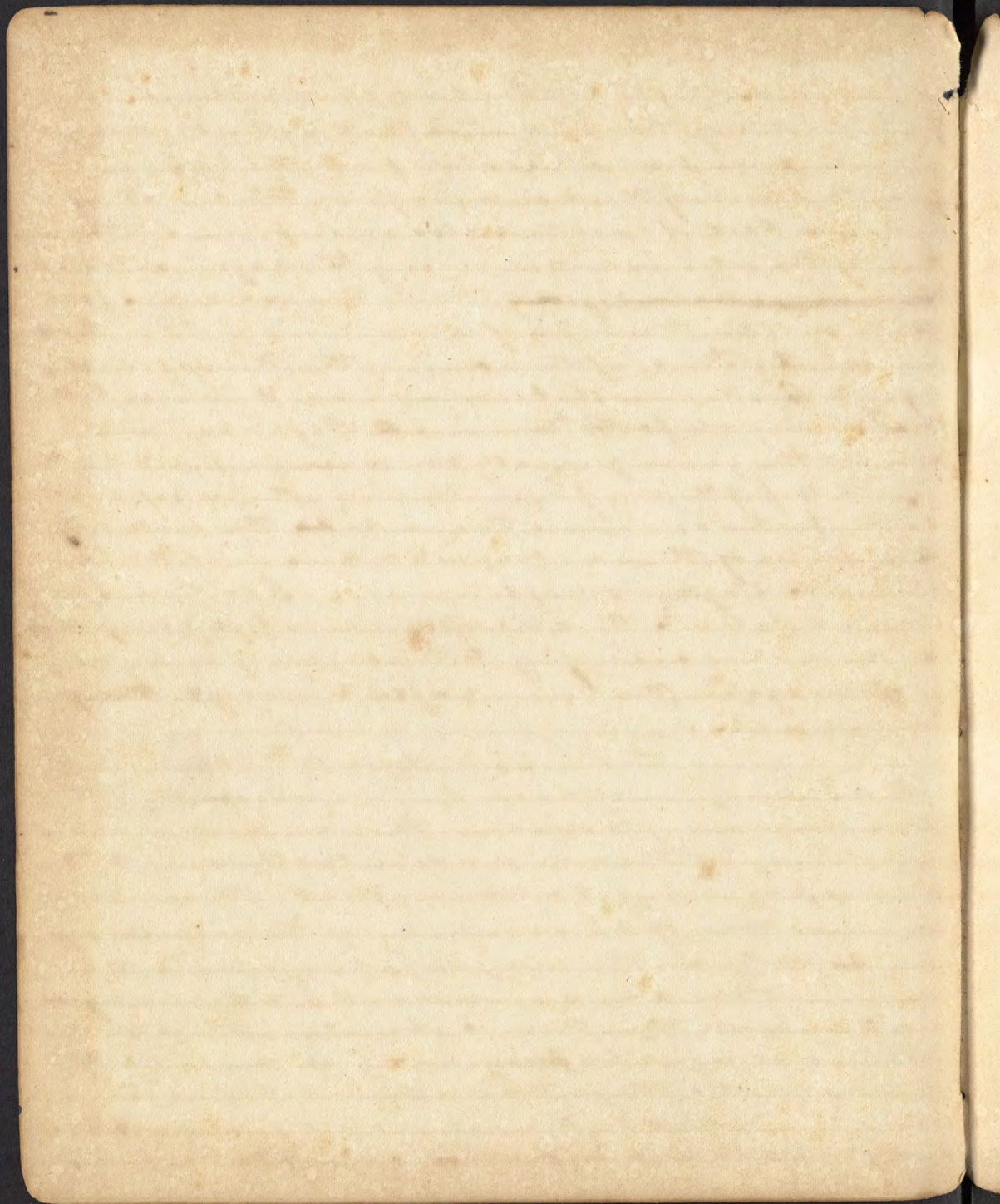
solar exertion, jumping, jolting, blows upon the abdomen, great and long continued exertion, powerful remedies, as emetics & cathartics, logot, strong doses, music, or any thing which will make a strong impression on the nervous system may be considered as exciting causes. Logot will sometimes produce it. But all these causes often fail. They are often criminally resorted to. Even some women of good character resort to them to prevent an increase of family. They almost always fail & are left afterwards to repent for their folly in some long continued disease of the uterus. I know a lady who told me that she jumped from the bed on the floor 60 times that she might produce abortion. She is now repenting with a disease which has been of long continuance & will probably ~~last~~ ^{live} with her till her death. The only means of certainly producing abortion is to resort to rupturing the membranes. - Some females abort so frequently that it may be said to be habitual with them. They will frequently abort at the same period of every pregnancy. How these causes operate is not very easily explained. It is well known that causes which operate on the organic life of a part will affect its animal life & vice versa. - The symptoms of abortion include all the symptoms of irritation of the uterus. Those powers which are called forth in regular labour are in action here also. The symptoms however, vary with the period in which it takes place. When it occurs in the first 4 weeks of pregnancy they are like those of a very painful menstruation, In the 2nd month there is more pain, the pains are more distinct, & alternate, the lower pain from organic irritation & pains from uterine action. We may here also have what are called false

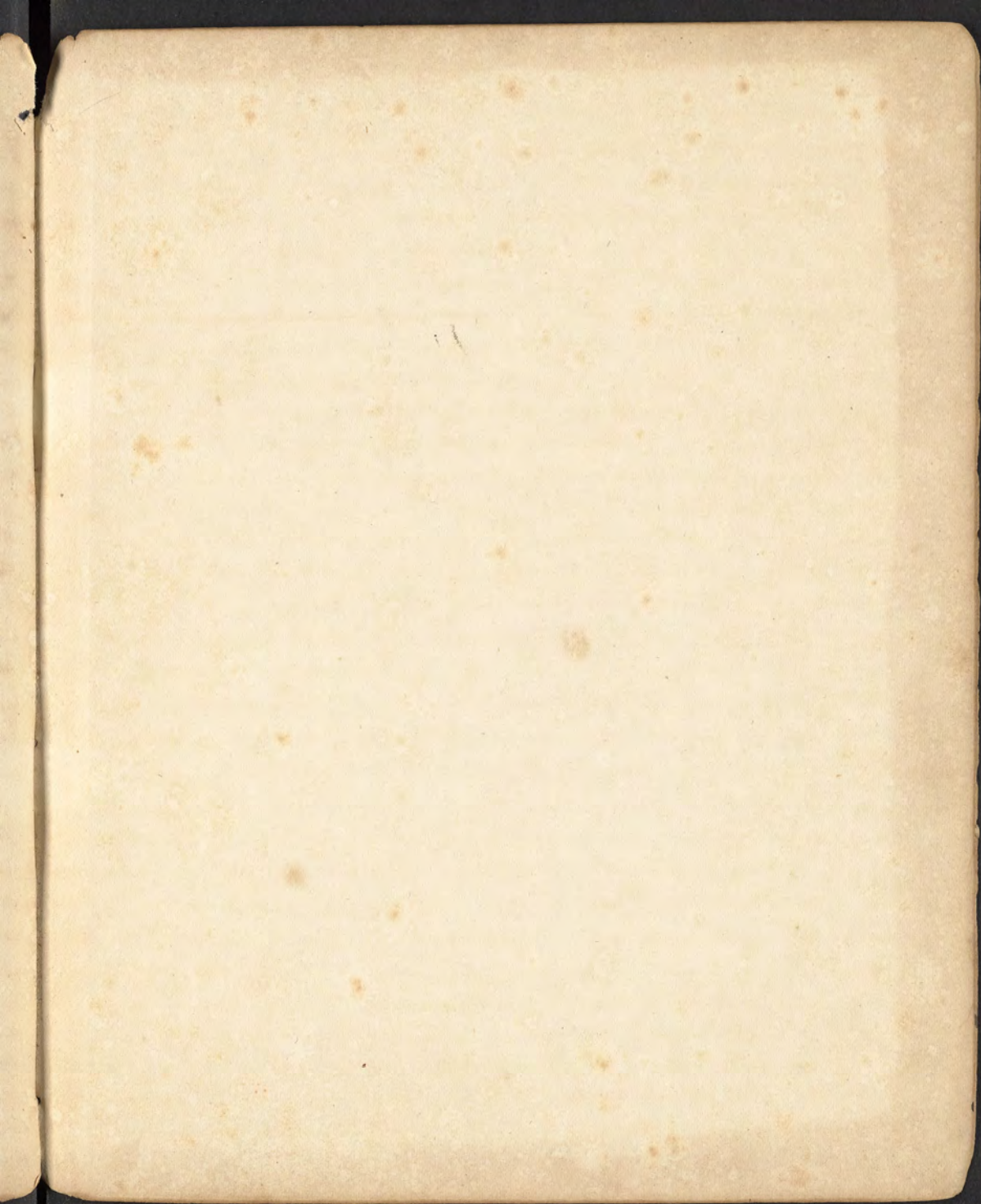
(Help me away from (Bartholomew, (Daguerre meant)
Determine you may want to lose money, so as to
be the same place in the region. (By the way, I am
or to the same place in the middle of the things & the same
distances may be sometimes referred to. (The same
of the house & kind of street and other parts are -
that from the same. (Noting the points in a lot
both names & the region he was is situated in the
general system. The same point is actually existing
but from the reason which (the place in the
region it is hardly not a continuity of place, but
separate. (By the way, which will give the sur-
face without necessarily eliminating the general
reasoning which has been so mentioned. (The
multiplicity are generally referred to, & are
specific. In the end, your point must stand to
the same way. In a large majority of cases there
is no change. (It is not in fact a matter
that is often seen. Of the treatment of (the
with great beauty. - On the (the place, action
interaction is a matter of decision to give
them. (Or this point. The same point stands
the point of view is necessary if there be no point
of view or gathering. (The same point stands
one and you are meeting the same point. (The
you are also saying (the same point stands
give rise to them. - On the (the place, action
process cannot be (the same point stands
as to action. It is generally referred to the
action, from (the same point stands
any number. (The same point stands
quantity only expressed from the same point)

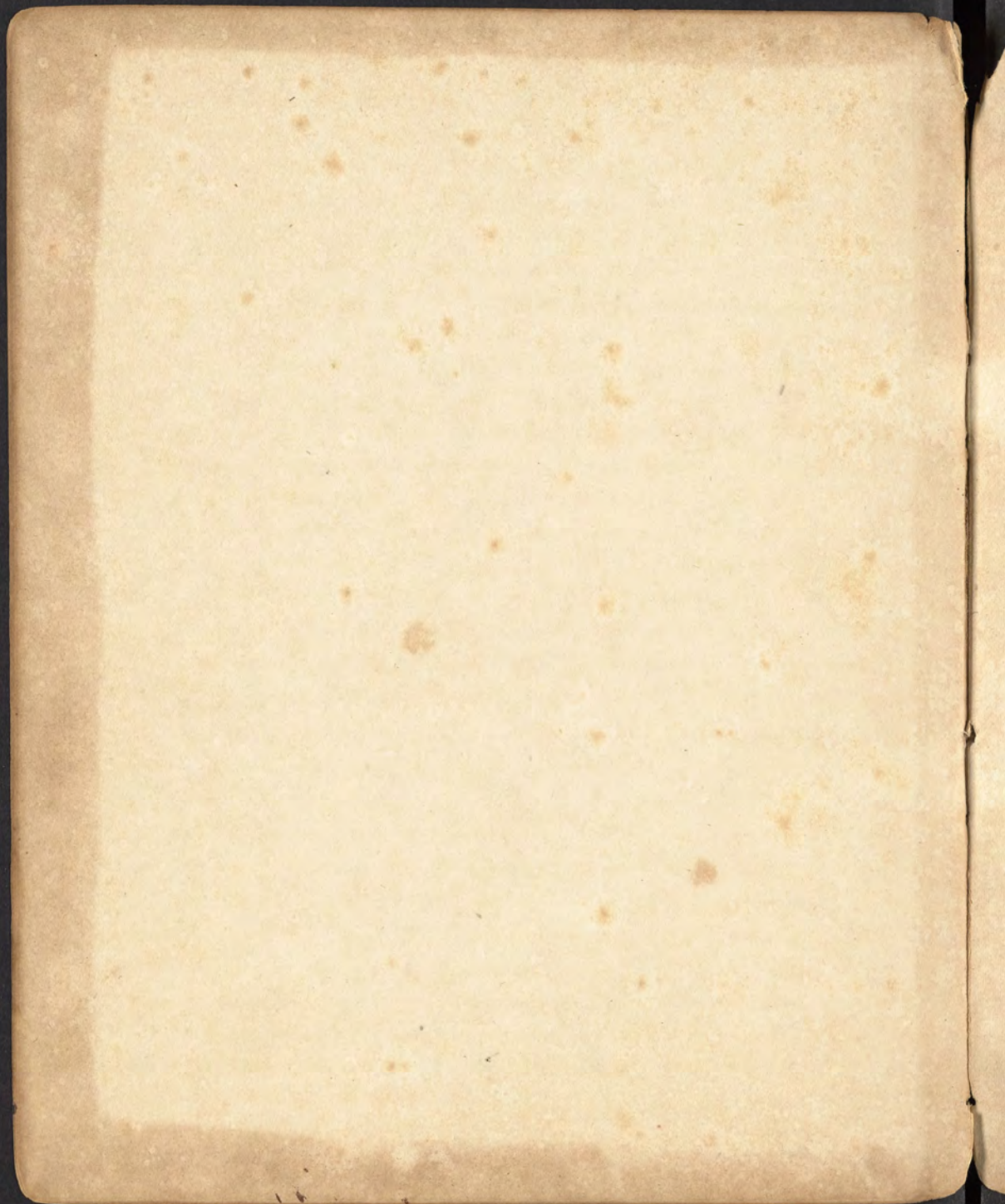
pains. The discharge is not so bloody, but watery, arising from rupture of the membranes. But watery discharges may also come from a secretion from the vagina, or from the neck of the womb, or from the bursting of pydatoids. A set of symptoms also arise from contraction of the uterus not necessary to be again detailed. ~~There may be rigidity~~ When this as it is felt to be delicate the hope of preventing abortion has vanished. The symptoms during the third, fourth, fifth & sixth months become more & more like those labour at full term in. As far as the 3^d month the ovum generally comes away entire, & in the fourth & fifth very frequently, but often separate. As the foetus advances to term so do the liability to rupture of the membranes & a division of the labour into stages more apt to occur. - Abortion is necessarily fatal to the child, & more or less dangerous to the mother according to the degree of irritability of her system, the hemorrhagic tendency, & the general condition.

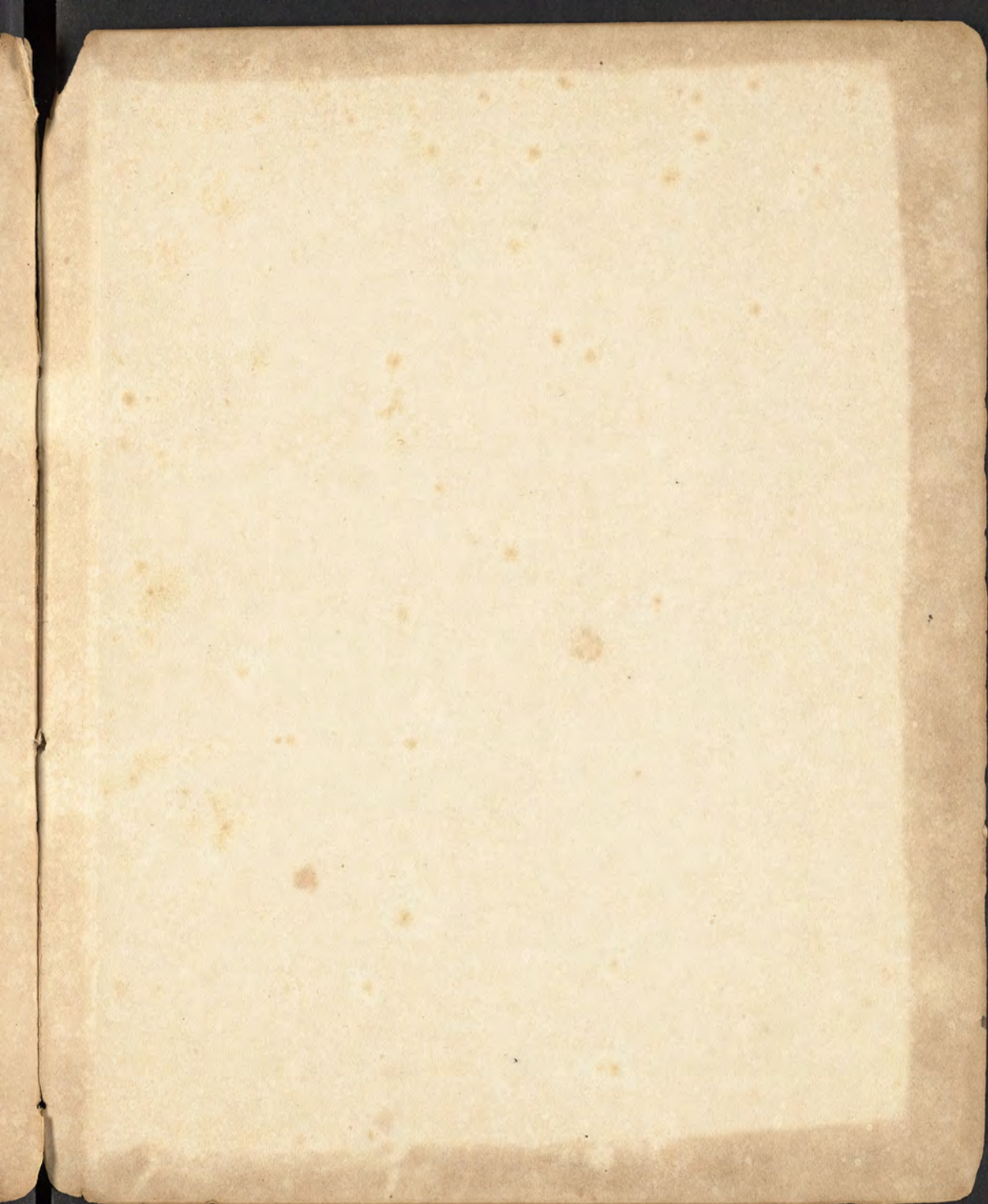
Lecture LII. March 15th 43.

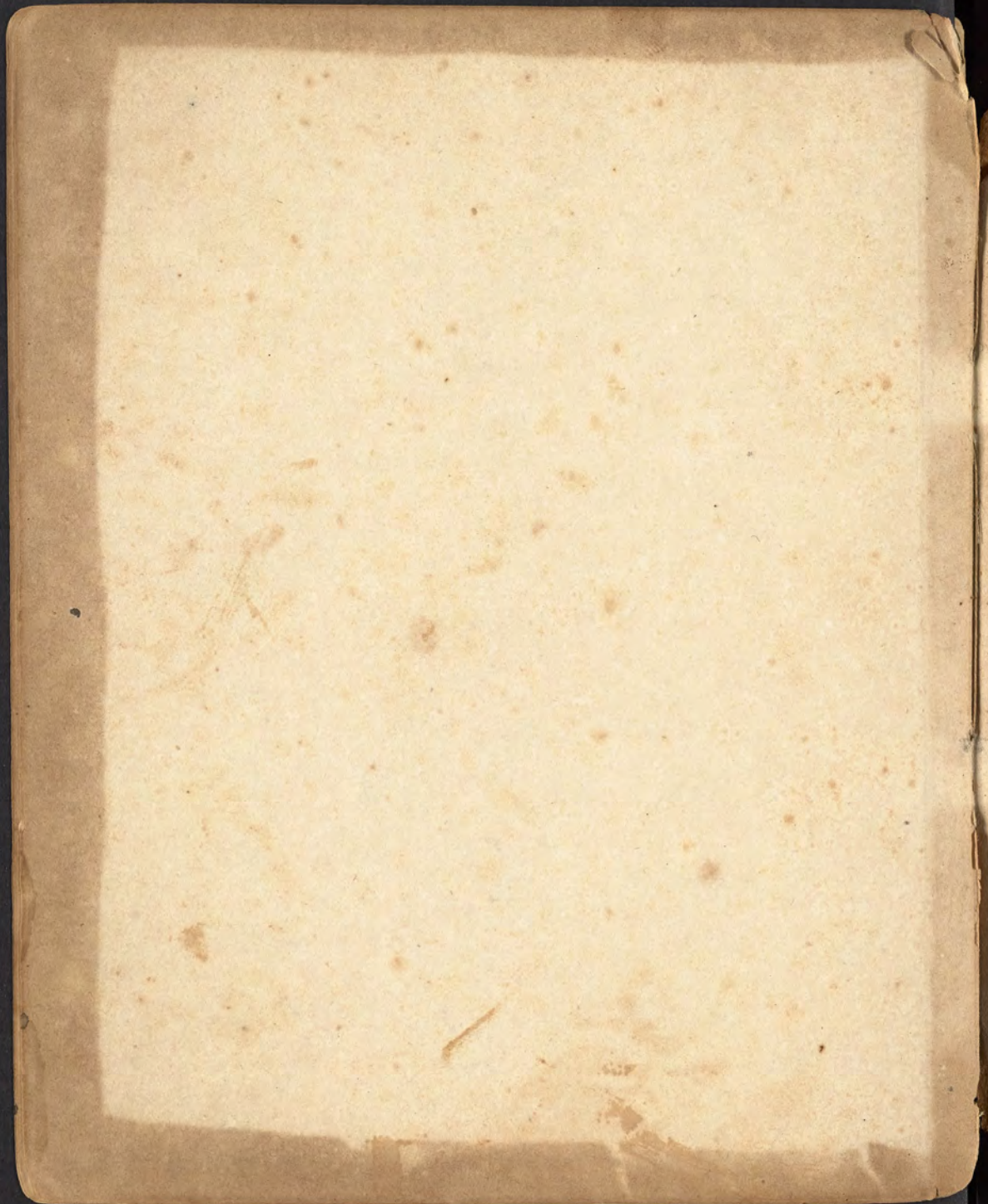
Of the management of abortion we say ~~that~~ the set place the means of prevention. These consist in removing uterine irritation which is done by attending to the causes, & by allaying it when very great. The causes are various. When there is excitement of the vascular system ~~at~~ plethora, the antiphlogistic system is to be employed. When there is morbid irritability, and degrees are to be used. When there is exhaustion, tonics & restitutions must be prescribed. Keep the patient's mind at rest. When there is the habit of aborting keep the patient in the recumbent posture, & do not permit moral influences to operate on her.











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